Does Management of Workplace Violence within the National Health Service Match Best Practice?

Andrew Boyce

University of Portsmouth
Institute of Criminal Justice Studies

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Title: DOES MANAGEMENT OF WORKPLACE VIOLENCE WITHIN THE NATIONAL HEALTH SERVICE MATCH BEST PRACTICE?

Submitted by: Andrew Boyce

Declaration: I confirm that, except where indicated through the proper use of citations and references, this is my own original work. I confirm that, subject to final approval by the Board of Examiners of the Institute of Criminal Justice Studies, a copy of this Dissertation may be placed upon the shelves of the library of the University of Portsmouth or made available electronically in the Library Dissertation repository and may be circulated as required.

Signed…………………………………………………………………………………………………………………………

Date…………………………………………………………………………………………………………………………
Abstract

In 2004, as part of the United Kingdom Government drive to tackle workplace violence in the National Health Service, the NHS Counter Fraud and Security Management Service, introduced Conflict Resolution Training to be delivered to all front line NHS Staff, along with a refresher course. Although the CFSMS stated the courses would be kept updated by current research and claimed them to be successful, to date the CFSMS have not provided any data to reinforce their claim with empirical evidence and the training courses remain unchanged.

This study focuses on identifying best practice for managing workplace violence by conducting a structured worldwide literature review of academic research into the subject and analysing whether it has been applied to the training provided by NHS Protect. The study concludes that, critically, while NHS Protect can claim to be advanced in terms of the types of specific training offered, it cannot provide any evidence to substantiate that best practice is being used in CRT due to a lack of structured course evaluation.

Furthermore, for NHS Protect to be in a position to offer training incorporating best practice, robust evaluation of the courses must be carried out in order to establish the training effectiveness to manage workplace violence. Additionally, there is a strong case for universal empirical research into training evaluation and effectiveness under a common definition of workplace violence to identify best practice from all industry sectors around the world.
Acknowledgements

Firstly I wish to thank my supervisor, Dr Nick Pamment, who has been a source of inspiration and played a significant role in supporting me to complete this research.

Love and thanks go to my daughter Jemma, for her support throughout. Finally I would like to pay a special thank you to my girlfriend Sarah for enduring the highs and lows of the last four years and without whom I would never have made it to the end.
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# Glossary of Terms and Abbreviations

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<thead>
<tr>
<th>Term</th>
<th>Title</th>
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<tbody>
<tr>
<td>NHS</td>
<td>National Health Service</td>
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<tr>
<td>CFSMS</td>
<td>Counter fraud and Security Management Service</td>
</tr>
<tr>
<td>SMS</td>
<td>Security Management Service</td>
</tr>
<tr>
<td>CRT</td>
<td>Conflict Resolution Training</td>
</tr>
<tr>
<td>NAO</td>
<td>National Audit Office</td>
</tr>
<tr>
<td>PVV</td>
<td>Patient and Visitor Violence</td>
</tr>
<tr>
<td>NHS Protect</td>
<td>NHS Protect (formerly NHS CFSMS)</td>
</tr>
<tr>
<td>LSMS</td>
<td>Local Security Management Specialist</td>
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</table>
Introduction

The aim of this study is to critically examine whether the management of workplace violence within the NHS matches best practice. Since the 1990’s, workplace violence has been a topic attracting much academic study (Minor, 1995, p. 4; Neuman & Baron, 1998, p. 392). Using national statistical data, Chappell and Di Martino (2006, p. 2) argue that workplace violence is in fact a worldwide problem transcending nations, occupational types and groups. The violence covers both physical and psychological violence emanating from within organisations or during interactions and engagement with people external to the organisation (Chappell & Di Martino, 2006, p. 2). Beech and Leather (2006, p. 31) argue that there is a significant economic and social cost to workplace violence, along with a negative impact on both organisations and individuals. Throughout this document the researcher will refer to NHS Protect, an organisation formerly known as NHS Counter Fraud and Security Management Service (CFSMS), which contained the division of the Security Management Service (SMS).

The problem within healthcare

As shown within figure 1, the NHS provides a vast number of patient facing services. These services are provided by the largest employer in the UK with a workforce of over 1.2 million (Health and Social Care Information Centre, 2012a). The NHS is a hugely diverse organisation providing healthcare to the majority of the population of the UK.
During the period 2011/2012, there were 17.5 million periods of patient care and hospital episodes recorded within the primary and secondary care sectors alone (Health and Social Care Information Centre, 2012b) indicating the vast number of contacts had with the public on a daily basis.

Due to the diverse nature of the work and the number of patient interactions experienced, healthcare as an occupation has been highlighted for attracting a higher rate of workplace violence compared to other professions (Upson, 2004, p. 9). In the United Kingdom, the British Crime Survey 2002/2003 identified health workers were at high risk of suffering workplace violence (Upson, 2004, p.9). Health workers have also been recognised as being at significant risk of workplace violence in studies conducted in the United States and Australia (Perrone, 1999, p.43). In 2003, the European Foundation for the Improvement
of Living and Working Conditions acknowledged via the European Parliament’s resolution that employers have responsibility for the health and safety of staff by risk assessing all risks, including that of workplace violence, and then preventing or managing the risk (Di Martino, Hoel & Cooper, 2003, p. 49). The same year a code of practice was introduced across a number of European countries identifying the need for policy, risk assessment, training and support in relation to workplace violence (Di Martino, Hoel & Cooper, 2003, p. 3). This highlights the worldwide concern towards workplace violence and the need for it to be managed.

Within the NHS, the department known as NHS Protect was launched in 2003. The department was given the responsibility for providing policy along with operational accountability for security management within the NHS (NHS Security Management Service, 2004, p.3). Coinciding with the launch of this service the National Audit Office (NAO) released a report entitled ‘A Safer Place to Work: Protecting NHS Hospital and Ambulance staff from Violence and Aggression’ (Comptroller, 2003, p.1). The report highlighted two earlier initiatives to tackle workplace violence originally launched in 1999. These were the ‘Zero Tolerance campaign’ and ‘Working Together, Securing a Quality Workforce for the NHS’ (Comptroller, 2003, p.2). The Zero Tolerance campaign sought to raise awareness of the unacceptability of workplace violence and the need to report incidents. The Working Together initiative required health bodies to have systems in place to record incidents and set specific targets aimed at reducing workplace violence (Comptroller, 2003, p.2).

The NAO report stressed that these measures were, in themselves, not enough to reduce workplace violence. This, along with a lack of reporting, made
measuring the scale of the problem difficult (Comptroller, 2003, p.5). The report concluded that NHS Protect would take responsibility for leading the work to tackle workplace violence within the NHS (Comptroller, 2003 p.5). As a result, in 2004 NHS Protect developed Conflict Resolution Training (CRT) to be used nationally for delivery to all front line staff (NHS Security Management Service, 2008, p.1). This training syllabus, set over 1 day, explores the different aspects of conflict and provides various methods to assist staff with managing conflict. The course specifically covers the subject of communication and behaviour, which are considered key elements to reducing incidence of workplace violence (NHS Security Management Service, 2008, p.1). However, incidents of violence, in particular assaults, have risen year on year since 2008 from 54,758 (NHS SMS, 2009a) to 59,744 in 2012 (NHS Protect, 2012a). It could be argued that training may not reduce workplace violence incidents and thus fails to have the positive effect desired by NHS Protect.

Additionally despite the fact assaults upon staff are increasing the CRT syllabus which has remained unchanged since launch in 2004 and has been proclaimed as “successful” by NHS Protect (NHS Protect, 2008, p.1). However, NHS Protect does not provide any evidence to corroborate this statement of achievement and thus it remains unknown how NHS Protect came to this conclusion. Statistics show assaults within the NHS are increasing. This, together with the unsubstantiated claim of success made by NHS Protect, puts the researcher, as an NHS Local Security Management Specialist, in an excellent position to undertake a focussed literature review to investigate whether the management of workplace violence within the NHS matches best practice. This paper will have immediate relevance to policy review offering the
opportunity to consider research which has emerged since the course was developed, and to consider future areas of research.

**Aim**

To critically examine whether the management of workplace violence within the NHS matches best practice.

**Objectives**

1. To undertake a global literature review to establish best practice in relation to workplace violence management.

2. Identify current best practice used for the management of workplace violence in the NHS.

3. Examine whether the NHS is using best practice to manage workplace violence and identify implications for the future and areas for further research.

The above three objectives will form the basis of the following chapter structure.

**Chapter 1 - Workplace violence management – best practice (Global review)**

Chapter 1 will provide an overview of the methodology used to conduct a structured literature review and ethics following which a review of literature based on best practice will be completed in order to identify best practice and emerging themes for discussion.

**Chapter 2 – NHS Current practice for management of workplace violence**

This chapter will provide an overview of current workplace violence training within the NHS. It will explore in detail the CRT course, and CRT refresher
course and highlight other training courses provided. It will evidence a lack of evaluation of the courses by NHS Protect and that they have failed to maintain currency of the courses or establish best practice since training commenced.

**Chapter 3 - Discussion and conclusion**

Chapter 3 will take the key themes identified from Chapter 1 and apply them to the NHS workplace violence training to establish whether best practice can be evidenced. The chapter will draw conclusions from the study and identify limitations and areas for future research.
Chapter 1 - Workplace violence management – best practice (Global review)

Introduction

Chapter one will provide an overview of the methodology used to conduct this structured literature review. In turn each of the 14 articles identified will be analysed in order to identify the research conducted into workplace violence and use of best practice, drawing out specific themes. Utilising the themes, the chapter will conclude with a suggested model to assist in establishing best practice to manage workplace violence.

Methodology

This research will take the form of a structured literature review. The aim of a structured literature review is to gather together evidence in order to organise findings of previous and current research and present what is already known about a specific subject (Schwandt, 2001, p.231) Robust and holistic understanding of the topic gradually builds as the knowledge increases, leading to greater confidence in applying any theory developed (Schwandt, 2001, p.229). Randolf (2009, p.3) discusses the goals of a literature review as being many, identifying for example, main themes or strengths or weaknesses to an argument. This is reinforced by Punch (2005, p.187) who asserts that without all the information a full picture cannot be obtained.

In order to examine whether workplace violence training within the NHS matches best practice a structured literature review is the most appropriate method to achieve the overall research aim as data from around the world can be analysed. This was achieved by searching databases such as the
Cumulative Index for Nursing Health (CINAHL), Cochrane Library, Science Direct and Emerald Fulltext for existing literature. A table of key search terms can be found in Appendix A. Following Cronin, Ryan and Coughlan’s (2008, p.39) recommendation a diary was maintained to record the database searches conducted. Due to the broad research field a strict search criteria was produced to include any article which met the following criteria:

- International data
- Articles dated after 2004
- Data written in English
- Academic journal articles
- Research based books
- Government policy documents
- Relevant research literature
- Grey literature (such as unpublished or in-house research)
- Data relating to primary and secondary care only
- Any article meeting the search criteria referenced within identified articles

And exclude:

- Articles, guidance or policy relating to mental health and ambulance workplace violence management as these staff receive more specialised and specific training (NHS Protect, 2011).
• Articles specifically detailing bullying, as this falls within the remit of Human Resources and not NHS Protect.

• Articles relating to ‘horizontal violence’ from colleagues.

• Articles identifying mechanical or pharmacological restraint of patients.

Many thousands of articles resulted from the combination of search terms. Articles of most relevance were reviewed with those not meeting the inclusion criteria excluded. 34 articles were selected. One article was unavailable through university library sources. A further 20 articles were excluded due to a lack of relevance to the specific research terms with a further article excluded due to poor translation into English. One article was included that did not meet the research terms but made specific reference to staff training in isolation of other topics. One Government sponsored review was included resulting in a total of 14 articles being reviewed.

In order to understand the literature gathered, Cronin, Ryan and Coughlan (2008, p.41) recommend that a structured method should be adopted, known as the PQRS system. This system allows each piece of data to be previewed (to get an understanding of each article), questioned (by examining the sources of information gathered), read and summarised in a consistent manner. Information from the data collected during this research was logged using the PQRS template preferred by Cronin, Ryan and Coughlan (2008, p.41) and can be found in Appendix B. Before profiling the results of the review it is important to briefly discuss any ethical considerations.
Ethics

Research is controlled by a number of ethical considerations of “right and wrong” (Hayden & Shawyer, 2010, p. 59). Punch (1994, p.89) describes ethics as the protection of subjects balanced against the freedom to research. Most ethical dilemmas focus on the protection of confidentiality and privacy, ensuring no harm is caused, obtaining appropriate consent and not deceiving research subjects (Punch, 1994, p.89). As this is a literature review, it is expected that all data will already be in the public domain and that the researchers will have gained ethical approval. This will be recorded and critiqued as part of the data collection and review process. In order to assist reading of this study, the table below identifies the qualitative and quantitative articles identified for this study.
<table>
<thead>
<tr>
<th>Author/year</th>
<th>Purpose</th>
<th>Method</th>
<th>Setting</th>
<th>Sample</th>
<th>Main findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rew/Ferns (2005)</td>
<td>To establish whether conventional NHS training can be enhanced by introducing training of an empathetic nature</td>
<td>Review article</td>
<td>Health</td>
<td>Nil</td>
<td>Greater improvements may be achieved by adopting alternative approaches and principles to enhance existing training for violent incidents</td>
</tr>
<tr>
<td>Nachreiner et al (2005)</td>
<td>To examine the impact of violence prevention training on work related physical assault</td>
<td>Literature review</td>
<td>Health staff from hospital and community settings</td>
<td>946 nurses</td>
<td>Violence prevention training has not been empirically tested as a preventative measure with more research required to identify the effectiveness and impact of workplace violence training.</td>
</tr>
<tr>
<td>Author/year</td>
<td>Purpose</td>
<td>Method</td>
<td>Setting</td>
<td>Sample</td>
<td>Main findings</td>
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<tr>
<td>Gates et al (2005)</td>
<td>To test the effectiveness of a violence prevention intervention to decrease the physical assaults against nursing assistants</td>
<td>Research article</td>
<td>Nursing Home</td>
<td>138 nursing assistants</td>
<td>No significant decrease in assaults post training.</td>
</tr>
<tr>
<td>Anderson (2006)</td>
<td>Determine the effectiveness of a 3 hour online training program for workplace violence</td>
<td>Pilot study</td>
<td>Hospital setting</td>
<td>43 staff</td>
<td>The number of reported assaults declined but training benefits were not easily identified.</td>
</tr>
<tr>
<td>Beech &amp; Leather (2006)</td>
<td>Review of staff training and integration of staff training models</td>
<td>Literature review</td>
<td>n/a</td>
<td>7 articles</td>
<td>The effects of staff training are rarely evaluated.</td>
</tr>
<tr>
<td>Author/year</td>
<td>Purpose</td>
<td>Method</td>
<td>Setting</td>
<td>Sample</td>
<td>Main findings</td>
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<tr>
<td>Leather &amp; Zarola (2008)</td>
<td>Provide an overview of workplace violence and identifies future actions</td>
<td>Literature review</td>
<td>n/a</td>
<td>n/a</td>
<td>Identifies the need for rigorous evaluation of training to help inform best practice. Identifies the advantages of a national database with research operating under common design principles.</td>
</tr>
<tr>
<td>Oostrom &amp; van Meirlo(2008)</td>
<td>Evaluate an aggression management program to cope with workplace violence in the healthcare sector</td>
<td>Research article</td>
<td>Health staff from hospital and community settings</td>
<td>42 staff</td>
<td>Significant improvement in assertiveness was identified following evaluation of the training course. There is a lack of academic research of the effectiveness of training.</td>
</tr>
<tr>
<td>Author/year</td>
<td>Purpose</td>
<td>Method</td>
<td>Setting</td>
<td>Sample</td>
<td>Main findings</td>
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<tr>
<td>Wassell (2009)</td>
<td>Determine the effectiveness of workplace violence intervention and comment on further interventions requiring more research</td>
<td>Literature review</td>
<td>n/a</td>
<td>Approx 54</td>
<td>Emerging but inconsistent training evaluation exists. There is a requirement for well designed future research.</td>
</tr>
<tr>
<td>Farrell &amp; Salmon (2009)</td>
<td>To provide a training model based on sound educational principles to meet national guidelines for managing challenging behaviour</td>
<td>Theoretical article</td>
<td>n/a</td>
<td>n/a</td>
<td>Their model will assist in developing further training for challenging behaviour. External, skilled trainers to work with organisations to implement training for challenging behaviour.</td>
</tr>
<tr>
<td>Author/year</td>
<td>Purpose</td>
<td>Method</td>
<td>Setting</td>
<td>Sample</td>
<td>Main findings</td>
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<tr>
<td>Kynoch et al</td>
<td>Establish best practice in the prevention and management of aggressive behaviour in patients admitted to acute hospital settings</td>
<td>Review article</td>
<td>Acute hospital</td>
<td>19 studies</td>
<td>There is some evidence to support training as part of the interventions to prevent and manage aggressive behaviour.</td>
</tr>
<tr>
<td>(2010)</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taylor &amp; Rew</td>
<td>Establish the characteristics of workplace violence in the emergency department in order to guide best practice models</td>
<td>Literature review</td>
<td>Emergency Department</td>
<td>16 studies</td>
<td>Difficulties exist around comparing studies due to a lack of common definitions of workplace violence. No meaningful evidence available from interventions used. Little progress made in developing research based best practice for managing workplace violence</td>
</tr>
<tr>
<td>(2010)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Author/year</td>
<td>Purpose</td>
<td>Method</td>
<td>Setting</td>
<td>Sample</td>
<td>Main findings</td>
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<tr>
<td>Gates et al (2011)</td>
<td>Implement and evaluate a violence intervention program over a 4 year period</td>
<td>Action research approach</td>
<td>Emergency Department</td>
<td>96 staff and patients</td>
<td>Highlight the importance of health and researchers to evaluate intervention strategies and publish results due to the lack of research into intervention effectiveness.</td>
</tr>
<tr>
<td>Kowalenko et al (2012)</td>
<td>Review of recent epidemiology and research on emergency department workplace violence and discuss the actions and resources necessary to reduce it.</td>
<td>Review article</td>
<td>Emergency Department</td>
<td>Nil</td>
<td>Found very few training interventions were evaluated to establish effectiveness and those that were failed to use rigorous methodology and design.</td>
</tr>
<tr>
<td>Author/year</td>
<td>Purpose</td>
<td>Method</td>
<td>Setting</td>
<td>Sample</td>
<td>Main findings</td>
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<tr>
<td>Hahn et al (2012)</td>
<td>Describe patient and visitor violence incidents and the measures used for dealing with them and the outcomes associated with healthcare staff working in different healthcare settings</td>
<td>Research article</td>
<td>Hospital</td>
<td>2495 staff</td>
<td>Training should be less generic and be designed to be ward or setting specific through empathetic communication with organisational commitment and support. Identify little research into workplace violence effectiveness.</td>
</tr>
</tbody>
</table>
Literature Review

Within the United Kingdom (UK), Rew and Ferns (2005) sought to establish if conventional training provided for managing conflict could be enhanced by introducing training of a more empathetic nature. They refer to the NHS CFSMS creating the CRT course but at the time assert that the precise detail of the training was “open to interpretation” (Rew & Ferns, 2005, p.228). The authors emphasize that self esteem, along with confidence, impact significantly on the ability of an individual to manage situations and that a breakdown of a cohesive team will further reduce the ability to manage conflict incidents (Rew & Ferns, 2005, p.231). In order to maintain and raise self esteem, Rew and Ferns (2005, p.231) proposed incorporating the philosophies taken from eastern martial arts, in the form of Aikido, to develop self esteem and confidence whilst maintaining an empathetic approach to violent situations, arguing that the focus of Aikido is based around acknowledgement, acceptance, calmness, focus and empathy.

Rew and Ferns (2005, p.232) conclude that having the ability to apply these principles alongside existing training methods could provide greater achievements with managing conflict situations. The authors do not provide empirical evidence that this approach has been tested and would have positive benefits.

In 2008, a report was produced for the UK Government Office for Science under the title “Mental capacity and Wellbeing: Making the most of ourselves in the 21st century”. The report specifically evaluates the scientific knowledge relating to workplace violence, including how it can be tackled (Leather & Zarola 2008, p.2). The authors highlight the difficulties in comparing research data due to the varying definitions used to describe workplace violence (Leather &
Zarola, 2008, p.3). Having discussed workplace violence risk and effects, two priorities specific to this research are outlined as:

1. The need for violence management training of any sort to be meticulously evaluated.
2. The need for comparative studies in violence intervention training to establish best practice.

(Leather & Zarola 2008, p.8)

The report concludes that the research and current interventions used are too individual by nature to compare, making collective learning difficult (Leather & Zarola, 2008, p.8). Additionally, the report argues that there is a need for a robust national database to capture data obtained by common research and design principles (Leather & Zarola, 2008, p.8). The report makes positive recommendations in order to address some of the current obstacles preventing identification of best practice in managing violence and aggression.

Turning to the United States of America (USA), Gates, Fitzwater and Succop (2005) conducted a study specifically within a nursing home setting to test the effectiveness of a violence prevention intervention to decrease physical assaults against staff. The study was conducted as a result of staff feeling under confident when dealing with violent incidents and that the training provided was difficult to understand and apply (Gates et al, 2005, p.120). In order to carry out the research the authors developed a staff survey on self efficacy, a nine hour training program and a violence prevention checklist (Gates et al, 2005, p.120). The training was developed utilising the principles of the Social Cognitive Theory (SCT) as designed by Bandura (1977) by
improving a staff member’s belief in their ability to succeed during a violent incident (Gates et al, 2005, p.121). Staff were required to complete the survey pre-and post-training and again six months later, during which they took part in a simulated exercise marked against the violence prevention checklist (Gates et al, 2005, p.121).

The findings of the study were that perceived knowledge, efficacy and skills improved significantly post training but crucially there was no significant effect on assault numbers (Gates et al, 2005, p.123). The test, repeated after 6 months, mirrored the previous findings in relation to perceived knowledge. However, there was little evidence of improved efficacy and skills or reduction of assault numbers (Gates et al, 2005, p.124). The authors concluded that the intervention did not reduce numbers of assaults and a zero tolerance approach to assaults should be maintained (Gates et al, 2005, p.126). The study was limited to assaults only, using a self generated definition.

Also within the United States, Nachreiner et al (2005) carried out a phased study over three years, questioning 310 trained nurses about training they had received associated with the prevention of violence, including the training in the use of physical security measures (Nachreiner et al, 2005, p.70). The research had many limitations such as no definition of training or evaluation of training quality leading to a much diluted overall conclusion that while workplace violence training is often recommended, it is seldom supported by empirical research (Nachreiner et al, 2005, p.76). The research also concluded that workplace violence does not have a significant effect on reducing violence and more research is required (Nachreiner et al, 2005, p.76). This study provides a benchmark for further in-depth study of workplace violence training programs.
In the following year, Anderson (2006) carried out a pilot study to establish the effectiveness of a three hour on-line training program to manage workplace violence in a United States hospital. A group of 43 volunteers at the hospital were split into a participating group and a control group, both being required to complete questionnaires pre-and post-training (Anderson, 2006, p.291). Ten staff completed the questionnaires and training required (Anderson, 2006 p. 292). To determine the effectiveness of the training, Anderson measured the numbers of reported workplace violence incidents prior to and post training, comparing them between the participating groups (Anderson, 2006, p.293). The study revealed a statistical reduction of reported incidents. The overall conclusion made was that it was difficult to establish the benefits of training and more research was required (Anderson, 2006, p.294). The author acknowledges the limitations of such a small study group, but does not fully explore the limitations of the method used to measure the effectiveness of training. It could be argued that incident levels may not have fallen as trained staff may feel more confident in dealing with incidents to the point of not considering them significant to report. This is further complicated by the fact no clear guidance is given on reporting near miss incidents. Overall the results of this research are considered of limited value.

Several years later, Gates et al (2011) commenced a four year study program to implement and evaluate a violence intervention program across six United States mid west emergency departments. The program commenced with twelve focus groups consisting of 71 staff and 25 patients, with the aim of establishing beliefs about violence and identifying strategies that will assist in violence management (Gates et al, 2011, p.34). The focus groups identified current
training to be inadequate, suggesting more interdisciplinary training was required (Gates et al, 2011, p.37). The authors assert the need for greater collaboration between hospitals and researchers around evaluation of training and intervention strategies, with data and best practice being shared in order to overcome the dearth of published research into successful interventions (Gates et al, 2011, p.38). As this study is ongoing results are yet to be produced. The study focuses on emergency departments, ignoring other departments that may add useful discussion to the focus groups and also benefit from the study findings. This is the only ongoing study to implement and evaluate training interventions for workplace violence identified in this research.

A number of studies have also been carried out in Europe and Australia. Evaluation of one specific aggression training program in the Netherlands was the key aim of the study by Oostrom and van Meirlo (2008). Highlighting the fact that little information exists about the effectiveness of training programs, Oostrom and van Meirlo (2008) commissioned a training syllabus specifically developed for healthcare by a training and consultancy agency comprising of three 4-hour training sessions covering assertiveness, aggression recognition, the effects of interaction with violent individuals and skills to manage violent situations (Oostrom & van Meirlo, 2008, p.323). The authors indicate a significant improvement of the insight into assertiveness and aggression among trainees along with a greater ability to manage volatile situations (Oostrom & van Meirlo, 2008, p.325). The major findings of the study are that few evaluations of aggression training are carried out and reported in academic literature. This research provides evidence of an effective program of training through the use of assertiveness and management of aggressive incidents.
(Oostrom & van Meirlo, 2008, p. 327). While the authors identify limitations with this study, they do not consider the very small sample size of 42 staff to be limiting. Additionally, it could be argued that the follow up questionnaire would provide more accurate data if left for a longer period. This may assist in determining the need for and frequency of refresher training. Whilst the article provides useful information regarding meaningful training content, the length of the course may be an unrealistic expectation without recognising the implications for organisations.

In an article by Farrell and Salmon (2009), they propose to meet national Australian guidelines with regard to challenging behaviour by using an exclusive training program based on sound educational values which consider the emotions and principles of nursing staff. The concept requires that staff identify how their own behaviour may have a negative influence on another’s behaviour, leading to an undesirable outcome (Farrell & Salmon, 2009, p.111). This is achieved by developing consideration of the impact of attitude, understanding of the others views and how the environment may affect the interaction (Farrell & Salmon, 2009, p.112). The model further uses evidence based knowledge to inform staff how to assess and react to incidents while remaining “street wise” to how situations can degenerate (Farrell & Salmon, 2009, p.113). The authors advocate the evaluation of training and conclude that the trainers will require a broad breadth of knowledge and expertise seldom found within health organisations (Farrell & Salmon, 2009, p.117). This is a theoretical article which presents no original research or data and is limited to the management of challenging behaviour. The article suggests skilled trainers will be required from outside of the organisation and draws attention to an
affiliated consulting organisation that provides trainers equipped with the desired skills. This creates scepticism around the conclusions made and commercial marketing which may be associated with article.

Hahn et al (2012) undertook a study in Switzerland to describe patient and visitor violence (PVV) at a hospital and the outcome of measures taken to manage them. The authors argue that although the subject of violence in healthcare has been widely studied, it has predominantly focussed on mental health and emergency department settings (Hahn et al, 2012, p.2686). Furthermore, as a consequence, most guidance and intervention strategies have also concentrated on these specific areas, potentially ignoring the fact that the majority of nursing staff work outside of these specialisations (Hahn et al, 2012, p.2686). The authors also argue that the lack of uniform definitions of workplace violence compound the problem of cross referencing research studies (Hahn et al, 2012, p.2686). The authors argue that there is a lack of studies into situational PVV which use the understanding of staff in different hospital settings to obtain an in depth analysis of these incidents (Hahn et al, 2012, p.2687).

The study of 2495 staff by questionnaire identified that, unlike other studies which highlight an increased confidence post PVV training, staff did not experience the same level of confidence to manage these situations (Hahn et al, 2012, p.2695). The authors posit that PVV training programs should be less generic and consider the very specific nature and location within the health setting of incidents to make it more explicit to individual staff groups (Hahn et al 2012, p.2695). The study concludes that training needs to be more focussed towards the situation and setting though empathic communication, with clear
organisational commitment to support staff (Hahn et al, 2012, p. 2696). Finally, the authors highlight the need for more research into the effectiveness of workplace violence training and strategies and that this research should include the perceptions of patients and visitors as well as staff (Hahn et al, 2012, p. 2696). The article refers to training limitations but does not state the component parts of the PVV training received, which makes it difficult to understand how the authors have identified training deficiencies. The study would have also benefitted from identifying the precise difficulties experienced by specific departments to assist in future research.

Five articles were based on literature reviews. Beech and Leather (2006) conducted a review of staff violence and aggression training with integration of training models by reviewing published workplace violence training along with training content and evaluation models. The study asked whether staff training is required along with how training can be measured and why training evaluation is seldom carried out (Beech & Leather 2006, p.32). Training is identified as part of the holistic approach to managing workplace violence but few published articles exist that describe specific training courses and their content (Beech & Leather, 2006, p.33). Beech and Leather (2006, p.41) conclude that the effects of training are rarely evaluated and propose an integrated model for evaluation, suggesting that evaluation should be included in the training program, complimenting the training, trainers, managers and researchers.

Similarly, Wassell (2009) conducted a systematic literature review into workplace violence interventions. Wassell (2009, p.1050) excludes any evaluation of workplace training programs which do not include the appraisal of
program impact on actual injury numbers. Although Wassell (2009, p.1054) asserts that research is emerging almost daily in this topic his most recent article is three years old suggesting that the author has not used the most recent articles available and consequently the findings may be inaccurate. Wassell (2009) fails to answer the research question and concludes by identifying the lack of study in this field that requires further research. Additionally, while interventions that could be collectively adopted are emerging, best practice within specific elements of training need to be identified (Wassell, 2009, p. 1054). This article identifies a lack of specific research to recognise best practice within training that can be measured effectively.

A year later Taylor and Rew (2010) analysed 16 articles in order to identify specific characteristics of workplace violence intervention studies in order to determine best practice for managing workplace violence in emergency departments. Having reviewed the articles, the authors argue that it is difficult to draw meaningful comparisons between them due to the varying definitions used to describe workplace violence by individual authors (Taylor & Rew, 2010, p.1081). They conclude that the studies failed to evidence any significant findings into interventions and overall, little progress has been made in the development of research based best practice for managing workplace violence (Taylor & Rew, 2010, p. 1083). This may be due to the fact the research was limited to emergency departments only with significant research findings found in other clinical areas. Overall the study acknowledges the lack of workplace violence intervention research denying the opportunity to establish best practice in emergency departments.
Conducting a similar review the same year, Kynoch, Wu and Chang (2010) specifically explored establishing best practice in the prevention and management of aggressive behaviour in patients admitted to acute hospital settings. Whilst the review made detailed reference to violence interventions such as mechanical constraints and the use of prescribed medication, the specific intervention of staff training was explored independently (Kynoch et al, 2010, p. 79) and therefore the article was included in this research. The article suggests that the use of “well designed” training programs can have a positive effect on staff ability to manage workplace violence incidents (Kynoch et al 2010, p.80). However, the term “well designed” is not defined in any way and not referred to elsewhere in the research making it unclear as to what the authors mean by this. The authors conclude by stating there is only “limited evidence to support the use of staff training” (Kynoch et al, 2010, p.84), suggesting a lack of research identifying the true benefits of this type of training. It could be argued that they have failed to answer the research question as best practice for managing aggressive behaviour has not been determined.

In 2012, Kowalenko et al conducted a review of recent research on workplace violence in the emergency department, including preventative measures and resources available to assist in workplace violence management. Whilst not setting out to identify best practice, the authors argue that there remain very few studies into workplace violence interventions (Kowalenko et al, 2012, p.526). Furthermore they argue even fewer workplace violence interventions have been studied to establish their effectiveness and those that have do not appear to have used thorough methodology or design (Kowalenko et al, 2012, p.526). This article has been included as it clearly identifies that as recently as
2012, there would still appear to be few robust evaluations of the effectiveness of workplace violence training which may provide evidence of best practice. It is also unfortunate that the article does not identify any specific studies other than that of Wassell previously referred to.

Chapter Summary

Chapter one highlights that whilst the subject of workplace violence management in healthcare has been extensively researched it would seem in most instants that this research has failed to go beyond identifying training as requirement. From the limited findings previewed it is clear a number of themes impact on the provision of best practice training for violence and aggression. These themes have been drawn together to produce a model to assist in identifying best practice.
Figure 2 - Summary of key themes in relation to establishing best practice training for violence and aggression

- Evaluation of current training must be carried out to establish effectiveness.
  - Ensure research is carried out in all areas of health provision to obtain a holistic view of specific needs.
  - Actively engage in empirical research to establish best practice in training.
  - Adopt a common workplace violence definition to aid comparison of data from different industry sectors.
  - Recognise that workplace violence figures may not reduce as a result of training.
  - Training will be: Based on empirically tested best practice principles proving greater support to staff members.

Evaluation of current training must be carried out to establish effectiveness.

Ensure research is carried out in all areas of health provision to obtain a holistic view of specific needs.

Actively engage in empirical research to establish best practice in training.

Adopt a common workplace violence definition to aid comparison of data from different industry sectors.

Recognise that workplace violence figures may not reduce as a result of training.

Training will be: Based on empirically tested best practice principles proving greater support to staff members.
Many studies have set out to answer a specific question about training effectiveness which would potentially lead to identifying best practice. Lack of training evaluation along with the use of generic training content, mixed definitions and overall lack of empirical research have hindered this process. It is suggested that the themes, as set out in Fig. 2 could be developed into a model to ensure robust methods are used in the process of managing workplace violence to identify best practice. These themes along with comparability of the NHS practices will be analysed in the next chapter.
Chapter 2 - NHS Current practice for management of workplace violence

Introduction

This chapter provides details of the current proactive training response used within the NHS to manage workplace violence. It will detail the origins of the CRT course, outline the course content and expected learning outcomes, along with reviewing the follow on refresher. Known evaluations of the training will be evidenced and their outcomes examined. Specific courses offered by NHS Protect will be discussed but will not form part of this particular study. It should be noted that, although the CRT course continues to be presented throughout the NHS by individual organisations, the guidance provided by NHS Protect regarding course implementation and the related refresher course was suspended in April 2012 for review (NHS, 2012b).

Conflict Resolution Training (CRT)

In 2003, the then Secretary of State for Health, John Reid, introduced the strategic document ‘A professional approach to managing security in the NHS’, (NHS SMS, 2004, p.3). This document sought to outline the strategic aims relating to ensuring the working environment for staff and those using the NHS remain safe and secure in specific response to the growing concerns towards the safety of staff from violence. At the same time the then Home Secretary directed all health bodies to:

“act in accordance with any guidance or advice provided by the NHS Protect to tackle violence against staff” (NHS SMS, 2004, p.6)
These two directions placed the onus on health bodies to ensure compliance in relation to any proposed management of workplace violence dictated by NHS Protect.

One key strand of the strategy focuses on tackling violence perpetrated against NHS staff. Whilst a series of reactive measures such as a national reporting system for assaults had been implemented, proactive management to prevent violence and aggression had not been considered until the NHS Protect developed a national syllabus of CRT to complement the existing measures outlined above (NHS SMS, 2004, p.4).

The CRT course was developed by NHS Protect in conjunction with the British Medical Association, Royal College of Nursing and the public service trade union UNISON (NHS SMS, 2004, p.5). The outcome led to a facilitated one day training course focussing on non physical techniques of conflict management for those staff who come into direct contact with the public (NHS SMS, 2004, p.5). The specific aim of CRT is to:

“recognise different aspects of conflict that delegates may encounter and understand and be aware of different methods of resolving such conflicts” (NHS SMS, 2008, p.1)

The objectives for course delegates are to be able to:

- Describe common causes of conflict
- Describe the two forms of communication
- Give examples of communication models that can assist in conflict resolution
• Describe patterns of behaviour they may encounter during different interactions
• Give examples of different warning and danger signs
• Give examples of impact factors
• Describe the use of distance when dealing with conflict
• Explain the use of reasonable force as it applies to conflict resolution
• Describe different methods for dealing with possible conflict situations

(NHS SMS, 2008, p.1)

In order that NHS Protect gain assurance that a consistent approach is taken, health organisations such as NHS acute, mental health and community trusts providing their own in-house training staff are required to have these individuals evaluated by NHS Protect prior to delivery of training. Once evaluated, in order to monitor the effectiveness of the training NHS Protect require health organisations to submit CRT training plans annually, detailing the number of staff projected to be trained along with details of how the organisation will provide the training (NHS SMS, 2004a, p.7). NHS Protect seeks to provide a standardised approach to CRT and to review organisations training strategies for the delivery of the course. However, these plans and strategy submitted to NHS Protect only provide projected numbers of staff to be trained, providing limited information for statistical purposes only. Reviewing the effectiveness of training requires internal evaluation of trained staff. NHS Protect provides neither mechanism for this nor information on evaluating effectiveness locally. As a result NHS Protect attempts to monitor effectiveness by an overview of the plans and strategy alone.
Conflict Resolution Training Refresher

Following on from the CRT syllabus, in 2007 NHS Protect introduced the CRT refresher training course to be completed by staff three years after initial CRT (NHS SMS, 2007, para.1). There is no rationale given for the need to provide refresher training within the NHS documentation although contact details are provided for further information (NHS SMS, 2004, p.6). The aim of the CRT refresher is to reinforce the training and previous knowledge gained from participating in CRT whilst “also exploring new concepts and increasing knowledge” (NHS SMS, 2007, para. 1). NHS Protect claimed this would be achieved by the revision of existing training material along with incorporating emerging relevant research as opposed to regurgitation of the standard CRT package (NHS SMS, 2007, para.1).

The guidance document provided by NHS Protect in relation to the CRT refresher authorises in-house trainers, who have already attended the familiarisation and evaluation training with NHS Protect to deliver the full CRT course, to devise their own “suitable course material” without any further input by NHS Protect (NHS SMS, 2007, para.8). The expectation is that evaluation of the refresher course is carried out by the health body itself to ensure the objectives have been met (NHS SMS, 2007, para.10). Whilst the content, structure and delivery of the full CRT course is managed closely by NHS Protect, management of the refresher course is devolved to organisations at a local level with reduced involvement from NHS Protect. It is unclear how NHS Protect expect health bodies to evaluate their own refresher courses without direction of national guidance. Furthermore, the suggestion that the course is constructed of locally indentified suitable material may lead to loss of control.
over the national syllabus. This may lead to the key aims of the training being lost. While review and control of the refresher course seems limited, NHS Protect have made attempts to evaluate the full CRT.

**Review of the CRT course**

In 2006, NHS Protect commissioned an in-house survey to establish the level of impact the CRT had on staff who attended the course between 2004 and 2005. The survey was based on questionnaires for the initial 12 month period of CRT delivery by NHS Protect trainers only (Quigley, 2006). The survey consisted of 6,141 questionnaires sent to all staff attending the training course. The questionnaire contained the following category headings:

1. Perceptions of safety and security at work.
2. Personal experience of abuse in the past 12 months.
3. Putting conflict resolution techniques into practice.
4. Dealing with abuse from members of the public.

(Quigley, 2006)

These categories are sub-divided into 22 separate questions. The response to each of the 22 questions is translated into bar graphs by the author although not all the data from questions asked is referred to (Quigley, 2006, p.6). This questionnaire was followed by a second, 12 months later, producing 810 responses (Quigley, 2006, p.6). An important point is made by Quigley (2006, p.7) that comparison of these studies cannot be made due to the sample compositions being very different. A general conclusion was made suggesting that those who had attended the course felt safer at work and the overall numbers of reported incidents of actual assault had decreased (Quigley, 2006,
Additionally, 90% of those surveyed stated that CRT provided the skills to manage verbal abuse compared to 63% pre-training. With regards to the ability to deal with physical assault, the numbers doubled (Quigley, 2006, p.2). The overall results demonstrated a positive reaction to CRT, particularly within ability and confidence to deal with abuse and physical violence. While limitations were observed, the report fails to take into account staff trained by individual health organisations which may have yielded different results. Furthermore, the survey did not include a control group resulting in the authors comment “it is impossible to know if any detected change is a direct result of this training course” (Quigley, 2006, p.7). As CRT is one element of a range of actions taken by NHS Protect to manage violence and aggression, without a control group the results of this survey are diluted further. Thus, the value of this study could be considered very limited. Evidence of later public perception surveys was requested from NHS Protect. It was confirmed that the surveys were discontinued in 2005 with no explanation available as to why (D Herrmann, personal communication, September 7, 2012).

Additionally, in 2010, NHS Protect commissioned the research company ipsos MORI to carry out a follow up study based on an original study carried out by ipsos MORI in 2004. The research aim was to increase NHS Protect’s understanding of staff’s experience of violence from public and patients in order to develop effective and proficient, preventive measures (Carluccio, Knychala & Marshall 2010, p.4). The detailed report attempts to capture information in relation to several security topics such as knowledge of the role of the LSMS, reporting incidents and CRT with the aim of identifying any priorities for the future (Carluccio, Knychala & Marshall 2010, p.15) The survey took the form of
a qualitative telephone questionnaire of 2202 staff from 25 specific staff groups (Carluccio, Knychala & Marshall 2010, p.18). The benchmark for results was taken from the 2004 survey. In respect of CRT, the report concluded staff attending CRT were more likely to agree the workplace was safe and secure against verbal abuse (Carluccio, Knychala & Marshall 2010, p.27). Additionally, there was a rise of 30% in respect of staff feeling more secure having attended CRT (Carluccio, Knychala & Marshall 2010, p.27).

Although the report concluded that CRT had a positive effect on staff in terms of being security aware, it did not specifically ask whether staff felt CRT provided the skills to manage workplace violence, nor did it scrutinise the course content or make recommendations in relation to it. It is difficult to see how the authors conclusions in relation to CRT can be directly attributed to it, when other factors such as incident reporting or knowledge of the role of the LSMS may have influenced staffs response to the question. While providing an overall assessment of staff experiences and perceptions of workplace violence, the report failed to critically assess whether CRT required any updating. In addition to the CRT course and refresher, NHS Protect have developed further training for specific sectors and areas of workplace violence.

**Additional Training**

In 2005 NHS Protect introduced two specific courses for mental health and learning disabilities trusts and one for the ambulance sector following the recognition that these services have significant numbers of incidents compared to other Sectors such as acute trusts (NHS SMS, 2005, p.1). The courses, known as ‘Promoting Safer and Therapeutic Services’ and ‘Implementing Learning Outcomes in Conflict Resolution for NHS Ambulance Services’ both
include physical intervention and breakaway techniques (NHS SMS, 2012b, p.1). Additionally, in line with the national remit to tackle workplace violence, NHS Protect have developed a course specifically designed to provide staff with skills to manage abusive and aggressive phone calls (NHS Protect, 2012c). The need for this course was borne from staff feedback for the CRT course which identified it as a specific area of need, (I Henderson, personal communication, 18 March 2013). This one day course, held at the NHS Protect training offices, provides staff who predominantly work on the telephone with the skills to de-escalate threatening or abusive callers. The course is only provided by NHS Protect and cannot be delivered in house by health bodies (NHS Protect, 2012c). Although additional information was sought from NHS Protect about course content and evaluation no further information was forthcoming which may suggest poor management of records or a reluctance to impart the information.

Chapter Summary

NHS Protect has been responsible for tackling workplace violence against NHS staff since 2003. A key strand of their proactive response is the provision of the CRT and CRT refresher courses. CRT provides a non physical resolution to workplace violence with the syllabus remaining unchanged since 2004. The refresher course reinforces knowledge previously gained from the CRT is though delivered locally with an implied expectation that health organisations update the syllabus through research, incorporating new developments in the field of managing workplace violence with little or no control from NHS Protect over the veracity of material used. Research carried out by and on behalf of NHS Protect in 2004 concluded that, overall, CRT has provided a positive effect
on staff and how they manage workplace violence. This research has many limitations particularly around the attribution of any success to CRT specifically. This review was not repeated so any meaningful comparisons cannot be made. The external review commissioned in 2010 aimed to enhance NHS Protect's understanding of violence towards NHS staff with a view to identifying future priorities. However, CRT content was not tested sufficiently for meaningful evaluation. There has been no centralised review of the content of either course since introduction which questions whether best practice is being used.
Chapter 3 - Discussion and Conclusion

Introduction

This chapter provides discussion and conclusions exploring the main themes from the research findings presented in earlier chapters. Each theme will be examined against current NHS practice to identify whether best practice is being used to manage workplace violence. Conclusions will be made from the themes and NHS best practice before addressing the study limitations and areas for further research.

Specific training

A number of the studies discussed in chapter 1 argued the need for training to be focussed on specific training needs. Beech and Leather (2006), along with Hahn et al (2012), highlighted that the training provided may not be specific enough to the needs of staff groups or particular working environments. In determining levels of current research into training, Kowalenko et al (2012) emphasised the lack of research into sector specific workplace violence training evaluation. It could be argued that training must become more focussed as the requirements of staff go far beyond a generic training course.

In this respect NHS Protect has recognised the need to provide a targeted approach, evident by the range of workplace violence training courses on offer in addition to the standard CRT course. Specific sectors such as mental health and ambulance services attract bespoke CRT courses. Furthermore, NHS Protect has identified the need for training in explicit areas as evidenced by the one day course on managing abusive telephone calls on offer (NHS Protect, 2012c). It is argued that NHS Protect are engaging best practice in relation to
targeting specific training needs throughout the NHS. However, the provision of specific training does not in itself define best practice, as courses require a degree of evaluation.

**Evaluation of training**

Nine of the fourteen articles considered discussed the requirement to evaluate current training. While there is little doubt of the benefits of such training (Brewer 1999, cited in Beech & Leather, 2006, p.31), there seems to be an almost complete lack of training evaluation taking place (Nachriener et al 2005, p.76, Oostrom & van Meirlo, 2008, p.320, Kowalenko et al, 2012, p.526). Training evaluation is the systematic collection of data to establish if the required outcomes have been met (Alvarez, Salas & Garofano, 2004, p.387) and argued to be the cornerstone of providing assurance of skill enhancement, effective performance and an ongoing desire to provide best practice (Weaver, Salas & King, 2011, p.341).

Anderson (2006, p.290) and Farrell and Salmon (2009, p.115) assert the need for evaluation to be an integral part of training, whilst Kynoch et al (2010, p.77) and Gates et al (2011, p.38) argue that there is a clear need for academic research and evaluation into workplace violence training to determine best practice. Additionally, of the few training interventions that have received evaluation, the research methodology and design have been criticised for failing to be robust (Kowalenko et al, 2012, p.526). This clearly identifies that whilst training to prevent or reduce workplace violence is embedded as a strategy for many organisations, the need to test the efficacy of the training in order to identify best practice is lacking. This raises the question of whether best practice is being used in those organisations and would account for the lack of
empirical data available. This would appear to be the most significant finding in relation to identifying best practice.

NHS Protect have provided CRT training since 2004 (NHS SMS, 2004, p.7) but, with the exception of the reports produced by Quigley (2006) and that of Carluccio, et al (2010), which offer little in the way of empirical data, no further centralised evaluation has taken place of this course. Furthermore, with the CRT refresher course content open to local organisation interpretation, it is unclear how NHS Protect can provide any assurance that either the CRT or CRT refresher courses are using best practice to manage workplace violence.

Effectiveness of training

If courses are seldom evaluated then their effectiveness may not be established. A number of studies concluded that only limited evidence exists of the value of workplace violence training. Anderson (2006, p.294) concluded that although her early research findings suggested favourable outcomes immediately after training, after six months the benefits had become difficult to identify. Likewise, in the study conducted by Kynoch et al (2010, p.84) the benefits of training could not be evidenced. The studies by Gates et al (2005) and Anderson (2006) measured effectiveness by calculating the reduction in reported assaults post training. Gates et al (2005, p.125) concluded that training failed to provide a significant decrease in reported assaults, though acknowledged that assault reduction may not be an accurate method of measuring effectiveness, suggesting alternative methods of measurement should be considered.
In the early research of NHS Protect’s CRT course conducted by Quigley (2006, p.18), the only conclusion made was that it had provided a positive impact on staff perceptions of safety and their perceived ability to manage workplace violence. There is no evidence of how effective the training is on staff ability to manage workplace violence. The later study carried out to understand how violence is experienced in order to “respond with effective and efficient preventative measures” (Carluccio et al, 2010, p.5) drew the following conclusion:

“Those who have attended CRT demonstrated increased awareness of other NHS initiatives as well as greater awareness and more positive attitude towards additional NHS security initiatives” (Carluccio et al, 2010, p.5)

This conclusion does not assist NHS Protect in meeting their own objectives of providing effective preventative measures. Neither study provided any evidence that CRT and refresher course are effective at preventing or reducing workplace violence. Additionally, NHS Protect only record numbers of assaults annually which, as discussed, may be a flawed method of measuring effectiveness.

**Definition**

Intrinsically linked to the themes of evaluation and effectiveness discussed above is the inconsistency of definitions used to define workplace violence. Although many studies of workplace violence have been carried out, this inconsistency makes study comparisons difficult (Beech & Leather, 2006, p.28,
Hahn et al, 2012, p.2686). As table 2 demonstrates, workplace violence has been described in the literature reviewed in this study as:

Table 2 - Workplace violence terminology

<table>
<thead>
<tr>
<th>Terminology</th>
<th>Author</th>
</tr>
</thead>
<tbody>
<tr>
<td>Violence</td>
<td>Rew and Ferns (2005)</td>
</tr>
<tr>
<td>Occupational violence, work related assault and work related violence</td>
<td>Nachreiner (2005)</td>
</tr>
<tr>
<td>Workplace violence which includes physical assault, harassment, threats and sexual assault</td>
<td>Anderson (2006)</td>
</tr>
<tr>
<td>Physical assault</td>
<td>Kowalenko et al (2012)</td>
</tr>
<tr>
<td>Verbal, non verbal and physical behaviour that is threatening to staff or property</td>
<td>Hahn et al (2012)</td>
</tr>
<tr>
<td>Physical and non physical assault</td>
<td>NHS SMS (2009b)</td>
</tr>
</tbody>
</table>

This clearly demonstrates how difficult it would be to draw comparisons between studies using these definitions and evaluate the data presented. In a report prepared for the UK Government by Leather and Zarola (2008) this lack of consistency is highlighted with the acknowledgement that the definition used by the European Commission is believed to be the best example of an inclusive definition of workplace violence being:
“incidents where persons are abused, threatened or assaulted in circumstances relating to their work, involving an explicit or implicit challenge to their safety, well being and health” (Di Martino, Hoel & Cooper, 2003, p.3)

In spite of this, whilst acknowledging the merits of an inclusive definition, Waddington, Badger and Bull (2005, p.158) outline the difficulties in determining what the terms, such as “threatening” and “violent” actually are, as it is often dependant on the perception and interpretation of the victim. Thus the difficulty can be seen with trying to identify a generic definition for all. In the absence of a generic definition NHS Protect have established two distinct definitions in order to clarify reporting requirements (NHS SMS, 2009b, p.7). The definitions are:

**Physical assault**

“The intentional application of force against the person of another without lawful justification, resulting in physical injury or personal discomfort”

**Non physical assault**

“The use of inappropriate words or behaviour causing distress and/or constituting harassment”

(NHS SMS, 2009a, p.7)

These NHS definitions allow for violence to be categorised and in respect of physical assault reported uniformly across England. While this may allow for consistency across the NHS, arguably the biggest organisation experiencing workplace violence, the value of comparing NHS studies with other agencies to
identify best practice may be weakened by the failure to adopt a more generic definition.

**Conclusion**

It is concluded that healthcare experiences high numbers of patient interactions daily and has been highlighted as an occupation at significant risk of workplace violence (Upson, 2004). The subject of workplace violence management in healthcare has been extensively researched but this research is limited, often failing to go beyond identifying training as requirement. From the limited research findings available it is clear a number of themes impact on the provision of best practice training for violence and aggression. Many studies have set out to answer a specific question about training effectiveness which would potentially lead to identifying best practice. Lack of training evaluation, failure to focus on specific areas of health provision and multiple workplace violence definitions have hindered this process. These themes have been developed into a model (Fig 2) to assist in identifying best practice.

Within the NHS, NHS Protect has been responsible for tackling workplace violence against NHS staff since 2003. A key element of its workplace violence management program is the provision of the CRT and CRT refresher courses, which have remained unchanged since 2004. The refresher course reinforces knowledge previously gained from the CRT but is delivered locally with an implied expectation that health organisations maintain the course currency with no external audit. Research carried out by NHS Protect in 2004 concluded that overall CRT has a positive effect on staff and how they manage workplace violence. This research is of limited value due to the weak research methods used. Notwithstanding the bold statement that training is “successful” (NHS
Protect, 2008, p.1) there is little evidence of effective evaluation. An external review commissioned in 2010, aimed to enhance NHS Protect’s understanding of violence towards NHS staff, failed to evaluate the CRT course specifically. Consequently there has been no centralised review of the content of either course since introduction.

Research suggests workplace violence training must be targeted towards specific staff groups, working areas and practices. NHS Protect stand out as they clearly provide a range of bespoke courses aimed at targeting specific needs. Whilst it is argued that training evaluation is essential to providing effective performance and identifying best practice, NHS Protect have failed to carry out any meaningful evaluation of their CRT courses. The use of best practice cannot be claimed and the effectiveness of training questioned. The lack of any inclusive definition of workplace violence across the discipline further reduces the usefulness of any study comparisons.

Having set out to establish whether management of workplace violence in the NHS matches best practice it is clear that due to the lack of research into training evaluation, effectiveness cannot be established and as a result best practice cannot be identified to address this. NHS Protect must establish a clear, auditable evaluation process for all training courses delivered to provide assurance that best practice is continually reviewed. This is an ideal opportunity for NHS Protect to become a significant authority on the provision of best practice to manage workplace violence. Whilst this study has limitations, some notable areas for future research have been identified and will be discussed below.
Limitations and considerations for future research

While it is hoped that this study provides meaningful considerations for the NHS and wider research field a number of limitations exist. The study would have benefitted from detailed primary research into staff members expectations, experiences and value pre and post violence and aggression training. This would complement the review of literature however time constraints prevented this approach. The inclusion of articles could not be verified by secondary evaluation leading to the possibility of author bias. Additionally it is recognised that much study has emanated from the mental health arena and although excluded from this research for the reasons provided, additional material to compliment this study may have been available. The inclusion criteria of articles after the introduction of NHS Protect’s CRT course in 2004 were intentional in order to establish current best practice. However, it is acknowledged that articles pre-dating this may have yielded further evidence of best practice. It should also be noted that training is one element of the holistic approach to managing workplace violence which includes security hardware, building design and other clinical interventions not covered in this study.

Notwithstanding the limitations above, the study has identified some key areas for future action and research. In particular, in order to ensure that management of workplace violence in the NHS matches best practice, NHS Protect must establish a robust evaluation process for all training courses delivered both nationally by them and locally by NHS organisations. A universal agreement on definition would allow detailed comparison of studies providing a much greater research base. Academic research must now move on from researching whether workplace violence exists within healthcare and concentrate on robust
empirical studies to identify best practice for the management of violence and aggression with engagement from the health sector.
Reference List


Appendix A – Literature review search terms

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<thead>
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<th>Primary search terms</th>
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<tr>
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<tr>
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<td>Workplace violence AND management NOT domestic</td>
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<tr>
<td>Training AND workplace violence NOT domestic</td>
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<td>Workplace violence AND training evaluation NOT domestic</td>
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<td>Workplace violence AND strategies NOT domestic</td>
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<td>Best practice AND workplace violence training</td>
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### Appendix B – PQRS template

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<th>Primary Source</th>
<th>Secondary Source</th>
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<td>Appraisal criteria</td>
<td>Content</td>
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<td>Recommendations</td>
<td>Summary/conclusions</td>
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<td>Key thoughts/comments e.g. strengths/weakness</td>
<td>Key thoughts/comments e.g. strengths/weakness</td>
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(Cronin, Ryan & Coughlan, 2008)