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Direct Staff's Experiences in Recognizing and Managing Psychiatric Symptoms in People With Intellectual Disabilities and Behaviour of Concern in Supported Accommodations

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ABSTRACT

The aim of this study is to explore the experiences of direct staff in managing psychiatric symptoms in people with intellectual disabilities and behaviors of concern in supported accommodation. The study has a quantitative, cross-sectional design using a questionnaire. Data were collected from 197 direct staff members working in supported community-based accommodation using an adapted version of the Checklist of Challenging Behaviour (CCB). The results show that staff experienced slight or moderate difficulty in managing psychiatric symptoms. The ratings were 38% for anxiety, 37% for compulsive behavior, 31% for manic behavior, and 49% for depressive symptoms. Direct staff members in supported accommodation face challenges in managing psychiatric symptoms and require educational training to improve their knowledge and skills. One viable option would be to implement web-based training programs. Further research and evaluation are imperative to improve access to mental health care for individuals with intellectual disabilities.

1 | Introduction

People with intellectual disabilities constitute approximately 1% of the population (Maulik et al. 2011). It is now recognized that their health profile is more complex than previously understood. A comprehensive review reveals that they have a significantly wider range of physical health conditions than the general population, highlighting the complexity of their health needs (Liao et al. 2021).

The prevalence of psychiatric ill health in adults with intellectual disabilities varies depending on the definition, examination, and diagnosis of the specific psychiatric condition. Mazza et al. (2020) conducted a systematic review of the prevalence of co-occurring psychiatric disorders in adults and adolescents with intellectual disability and found that mood disorders are the most common (prevalence of 6.7%), followed by anxiety disorders (5.5%), unspecified psychotic disorder (3.9%), and schizophrenia (4.8%). According to Deb et al. (2022) the overall rate of major functional psychiatric disorders such as schizophrenia, depressive disorder, bipolar disorder, and anxiety disorders among adults with intellectual disabilities falls within the range of 14.4%–22.4%. Thus, the prevalence of broader psychopathology is much higher in adults with intellectual disabilities than in the general population (Axmon et al. 2018; Mazza et al. 2020; Peña-Salazar et al. 2018). It is therefore important to explore the experience of the direct staff managing psychiatric symptoms among adults with intellectual disabilities.

Given the wide range of mental health challenges within the population of individuals with intellectual disabilities, it is imperative to address the need for appropriate care and support

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and to develop effective interventions to manage signs of psychiatric ill health. For example, given the high prevalence of anxiety disorders, caregivers should proactively consider providing additional support during significant life events and should be vigilant in identifying early signs of emerging mental health problems (Reid et al. 2011). To give another example, diagnosing schizophrenia in individuals with limited cognitive abilities and communication skills poses challenges. It is thus very important that direct staff members observe changes in individuals' behaviour and mood (Deb et al. 2020).

Diagnostic overshadowing is a well-known phenomenon where symptoms are incorrectly attributed to a known diagnosis of intellectual disability. As a result, individuals with intellectual disabilities may not receive appropriate care (Dell'Armo and Tassé 2024). A review of 106 studies in mental health and intellectual disabilities found that advanced psychiatric care was linked to improvements in mental health, social functioning, behavior, and forensic risk. Two main models of care were identified: specialist intellectual disability inpatient services and general mental health services. Patients in specialist services experienced greater complexity but had better outcomes, including fewer out-of-area discharges and lower seclusion rates. Overall, the evidence suggests that in-patient admission benefits mental health, with some indications of better outcomes in specialist services (Melvin et al. 2022). This aligns with research showing that mental health services often struggle to meet the needs of individuals with intellectual disabilities and co-occurring mental health conditions (Lake et al. 2021; Weise et al. 2020).

The increased prevalence of psychiatric symptoms in this population is observed both independently and simultaneously. However, diagnostic overshadowing is a limitation in accurately diagnosing mental health conditions in individuals with intellectual disabilities, as symptoms are often misattributed to their intellectual disability. Main limitations in this area include fundamental differences in diagnostic constructs within the field of intellectual disabilities, inconsistent definitions of behaviours of concern (BC) and the overlap between these two issues (Bowring et al. 2019).

BC are frequently observed among people with intellectual disabilities, particularly when accompanied by mental health issues. The behaviors have been identified in approximately one in 5 or 6 adults with intellectual disabilities and significantly impact their quality of life (Bowring et al. 2019). BC are often attributed to communication difficulties, psychosocial vulnerabilities, limited social networks, and psychiatric or mood problems. Biological factors such as overall health, sensory issues, and genetic factors also contribute to these behaviors (Hastings et al. 2013). When addressing psychiatric symptoms in people with intellectual disabilities and BC, interventions must consider these social and biological factors. The manifestation of BC can be influenced by communication disorders, the level of intellectual disability, and the type of accommodation and care provided. Given that the relationship between intellectual disabilities, BC, and mental health is complex and multifaceted (Bowring et al. 2019), it is important to shed light on the crucial role played by direct staff members working in supported accommodation and families living in close proximity to people with intellectual disabilities and co-occurring psychiatric ill health. The staff are the ones who can observe and report their mood changes and psychiatric symptoms (Weise et al. 2020).

Direct staff members serve as support assistants in supported accommodation and are responsible for assisting and supporting clients in their daily lives, work, and other activities such as housework. Additionally, they provide healthcare support when required (Truong et al. 2023). As they carry out these diverse tasks with people with intellectual disabilities, direct staff encounter a variety of challenges in understanding and interpreting the needs of people with multiple disabilities. They often encounter communication barriers and challenging behavior, as well as physical and psychiatric symptoms (Bigby et al. 2014; Bowring et al. 2019; Yoo et al. 2012). Furthermore, direct staff in group homes wield significant influence and power over residents, which they must handle with care (Svanelöv et al. 2020). Direct staff members play a vital role in supporting people with intellectual disabilities with psychiatric symptoms and BC and facilitating their social interactions and engagement in meaningful activities. This support can have a significant impact on reducing the occurrence of BC. However, according to Taua et al. (2012), there is a lack of precise formulation regarding the roles and responsibilities of registered nurses in caring for people with intellectual disabilities and psychiatric symptoms.

A review of the knowledge, attitudes, and perceptions of direct staff members towards people with intellectual disabilities, psychiatric symptoms, and BC highlighted a lack of knowledge and competence in addressing their needs. This review emphasizes the importance of education and training to ensure staff members are adequately prepared and capable of providing effective support (Ee et al. 2022).

Despite the higher prevalence of psychiatric ill health among people with intellectual disabilities, a study conducted in Sweden by Nylander et al. (2016) revealed that as many as 20% of patients with intellectual disabilities receiving psychiatric care did not have specific psychiatric diagnoses. Their study highlights the issue of underdiagnosing individuals with intellectual disabilities and raises concerns about the risk of inadequate support and undertreatment. Similarly, a study conducted in Spain by Peña-Salazar et al. (2018) found that 30% of institutionalised adults with intellectual disabilities had undiagnosed psychiatric comorbidities. Their study also emphasizes the challenges in accurately identifying psychiatric symptoms in this population and the potential consequences of neglecting appropriate support and treatment.

Axmon et al. (2016, 2018) found that people with severe/profound intellectual disabilities receive psychiatric diagnoses less frequently than those with mild and moderate intellectual disabilities. The reasons for this disparity, whether differences in the prevalence of disorders or diagnostic difficulties, have yet to be fully clarified. Communicative obstacles and BC are recurring topics in this context. Staff members are often required to manage complex and challenging situations with limited support and guidelines (Taua 2015). To avoid neglecting these complex conditions, it is important to study the experiences of direct staff in managing psychiatric symptoms in people with intellectual disabilities and BC in supported accommodations.

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1.1 | Aim

The aim of this study is to explore the experiences of direct staff in managing psychiatric symptoms in people with intellectual disabilities and behaviors of concern in supported accommodation.

2 | Method

2.1 | Study Design

This study uses a cross-sectional design to examine the experiences of direct staff members in managing psychiatric symptoms among residents with intellectual disabilities. This study is part of a larger research project that evaluates the effectiveness of a web-based training programme focusing on intellectual disability, BC, and communication and interaction. The study adopts a quantitative approach, using a questionnaire as the primary data collection method. To ensure detailed and comprehensive reporting of the quantitative study, the researchers adhered to the guidelines provided by the "Strengthening the Reporting of Observational Studies in Epidemiology" (STROBE) framework.

2.2 | Context

The study was carried out in a municipality in Sweden with a population of approximately 60000 inhabitants and surveyed twenty sites offering supported accommodation to people with intellectual disabilities. The staff members offered 24-h assistance to individuals with intellectual disabilities, but on-site management or supervisory personnel were not present to provide support on a regular basis. However, in exceptional circumstances, a manager and experts in assisting people with intellectual disabilities would offer assistance, particularly in education, caregiving, and healthcare-related matters. The residents usually lived in group-home units housing 2–12 individuals or in their own apartments, which were referred to as 'assisted living facilities'. The accommodation provided amenities such as a joint meeting area, individual rooms, a larger living room, a shared kitchen, and a dining room. Most of the residents engaged in organised daily occupations outside the accommodation. The most common diagnoses among the residents, per the International Classification of Diseases ICD-11 by the World Health Organisation (WHO), were moderate, severe, and profound intellectual disabilities. Additionally, many residents also experienced multiple communication challenges such as deafness, blindness, and mutism. Sign language, short sentences, and visual cues were sometimes necessary to support communication.

2.3 | Participants and Procedure

All direct staff members, totaling 212, were invited to participate in web-based training. Most of the participants had completed upper secondary education with a focus on healthcare, while only a few had pursued a university education in social care. They were responsible for supporting individuals with intellectual disabilities in their daily lives. Initially, the web-based training started by answering a questionnaire based on the CCB. One hundred and ninety-seven staff responded. Reminders were sent out twice. Returning a completed questionnaire was regarded as constituting written consent to participate in this study. The questionnaire was distributed to staff in hard copy format, as it was believed that doing so would make it easier for staff to complete and return the survey instrument. Reply envelopes were attached to the questionnaire so that the staff could return them by mail.

2.4 | Instrument

In this study, which is part of a more extensive study, seven items representing the frequency and difficulty of managing psychiatric symptoms were added to the Checklist of Challenging Behaviour (CCB) (Harris et al. 1994). The CCB was used to measure staff members' experiences relating to intellectual disabilities and BCs. According to Harris et al. (1994), Joyce et al. (2001) and Mills and Rose (2011), the CCB has an acceptable level of content validity and reliability. The instrument has not been tested with the addition of these seven questions but was used in the following studies (Truong et al. 2023) and (Pusa et al. 2019). The results were considered important enough to address even though testing has yet to be done on the seven added questions. These items concerned signs of depression, signs of anxiety, voice hallucinations, compulsive behaviour, agitated speech, manic behaviour, and other psychiatric behaviours. Additional questions were related to how often the symptoms occurred (frequency) and difficulties experienced in managing the psychiatric symptoms (management difficulties). An example of a question was: Did the individual show signs of anxiety monthly, weekly, or not at all? How difficult was it to manage these difficulties: slight, moderate, considerable, extreme, or no problem?

2.5 | Assessment and Analysis

In the adapted version based on the CCB used in this study, the original 5-point Likert scales for frequency and managing difficulties were converted into 3-point Likert scales, as shown in Figures 1 and 2. In the original 5-point frequency scale, 1 (never) was changed to 1 = not at all; 2 (once a week) and 3 (a few times a week) were collapsed into 2 = occurring monthly; 4 (once a day) and 5 (a few times a day) were collapsed into 3 = recurring weekly. The scale representing the assessment of managing difficulties was changed as follows: 1 (no problem) was left unchanged; 2 (slight problem) and 3 (moderate problem) were collapsed into 2 = slight or moderate problem; 4 (considerable problem) and 5 (extreme problem) were collapsed into 3 = extreme problem. According to Harris et al. (1994), 'considerable problem' means it is very difficult to manage the situation without help. An 'extreme problem' is one that a person cannot manage without help. Since there were fewer than 10 items (Briggs and Cheek 1986), the homogeneity of the Swedish version of the CCB was analysed by calculating inter-item correlation. In this study, the inter-item correlation for the frequency of psychiatric symptoms showed a mean value of 0.44. The mean value for managing the difficulty of psychiatric symptoms was 0.51. Data

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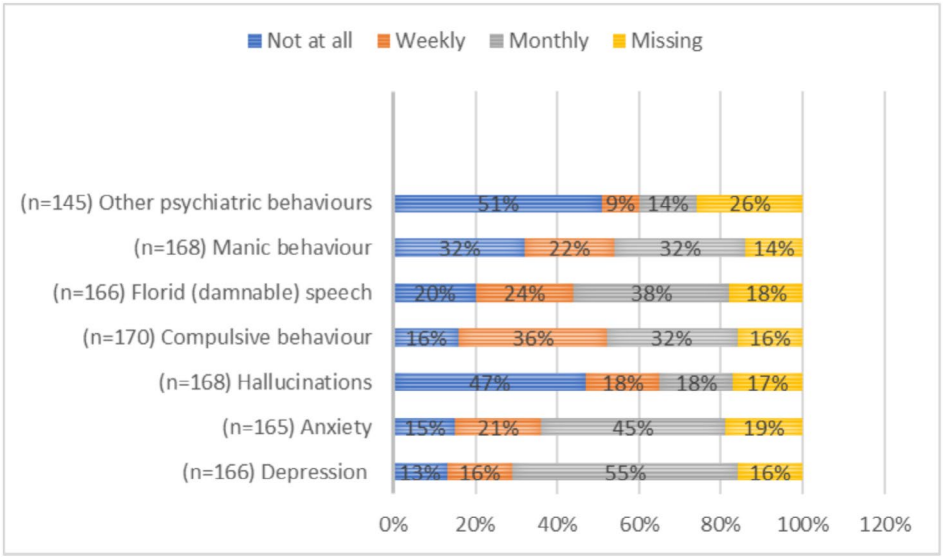

FIGURE 1 | The frequencies of staff reporting psychiatric behaviours among residents.

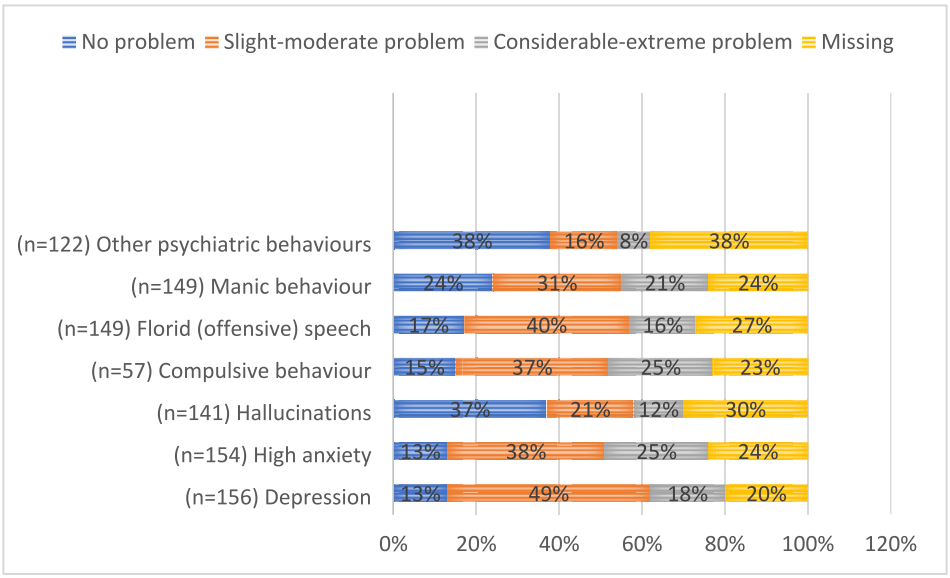

FIGURE 2 | The staff reporting difficulties in managing psychiatric symptoms and behavior of concern.

were analysed using the SPSS statistical software (IBM Statistic Package for Social Sciences), version 25. Descriptive statistics were used to summarise the frequency of psychiatric symptoms and managing difficulties in the Swedish version of the adapted version based on CCB.

2.6 | Ethical Considerations

The study obtained ethical approval from the Swedish Ethical Review Authority, with registration number Dnr. 35517 Staff members who did not wish to participate or wanted to withdraw from the study were given the option to do so without having to provide reasons for their decision. Although the questionnaire included sensitive questions related to scales and potential mistakes in care, the risk was deemed negligible. The confidentiality of all collected information was strictly maintained throughout the study to ensure the privacy and anonymity of the participants.

3 | Results

The participants in the study were staff members working in a community-based facility that oversaw 20 supported accommodations for people with intellectual disabilities. Usually, each of the 20 accommodations had between 6 and 18 staff members providing support for between 2 and 12 individuals with intellectual disabilities. Most of the participants had completed upper secondary education with a focus on healthcare, while a few had pursued a university education in social care. The participants included 160 women and 52 men aged between 22 and 68 (Md 45). Their working experience with people with intellectual disabilities ranged from 0 to 45 years (Md 7). The participants

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had to be permanently employed and had to have mastered the Swedish language.

3.1 | Psychiatric Symptoms

Regarding compulsive behavior, the staff ($n = 170$) reported that 36% observed this behavior weekly (while 32% perceived it as occurring monthly. 16% indicated that they did not observe compulsive behavior at all, and 16% missing i.e., chose not to respond to the question). Staff ($n = 168$) rated the monthly frequency of manic behaviour at 32% (32% not at all, 22% weekly and 14% missing). For foul (offensive) speech, the staff ($n = 166$) rated a monthly frequency of 38% (24% weekly, 20% not at all, and 18% missing). The monthly frequency of showing signs of depression was rated by the staff ($n = 166$) at 55% monthly (16% weekly, 13% not at all, and 16% missing) (Figure 1). The frequency of "not at all" was highest for other psychiatric symptoms (51%) and signs of voice hallucinations (47%). The percentage of missing responses among the seven different behaviours ranged from 14% (manic behaviour) to 26% (other psychiatric behaviours). (Figure 1).

3.2 | Managing Difficulties

The staff experienced difficulties in managing psychiatric symptoms and BC among residents with intellectual disabilities. For anxiety levels, the staff ($n = 154$) estimated managing difficulty as slight or moderate to 38% (25% considerable or extreme problem, 13% no problem, and 24% missing). For compulsive behavior, the frequency estimated by the staff ($n = 57$) was slight or moderate at 37% (25% considerable or extreme problem, 23% missing, and 15% no problem). For manic behavior, the frequency estimated by the staff ($n = 149$) was slight or moderate problems at 31% (24% no problem, 24% missing, 21% considerable or extreme problem). Of the staff ($n = 156$), 49% experienced slight or moderate difficulties managing people with intellectual disabilities and BC who showed depressive symptoms (20% missing, 18% considerable or extreme difficulties, and 13% no problem) (Figure 2).

The frequency of 'no problem' was highest for other psychiatric symptoms and voice hallucinations, at 38% and 37%, respectively. The percentage of missing responses among the seven behaviours ranged from 38% (other psychiatric behaviours) to 20% (compulsive behaviours) (Figure 2).

4 | Discussion

The aim of this study was to explore the experiences of direct staff in managing psychiatric symptoms in people with intellectual disabilities and BC in supported accommodation. The findings revealed that a notable percentage of staff members (up to 67%) considered depression to be a challenging problem to manage among people with intellectual disabilities. Some 18% described handling depression as a considerable or extreme problem. Similarly, staff members regarded managing anxiety in people with intellectual disabilities as nearly as difficult as managing depression, with 25% reporting it as a considerable or extremely difficult task. The study also highlighted that approximately one-third of the staff members reported residents exhibiting psychotic symptoms, such as hearing voices. Handling these symptoms was considered considerably or extremely difficult in 12% of the responses. Compulsive behaviors were also commonly observed among residents, which raises the question of whether they were a result of disability or mental illness. In this regard, 25% of the staff members considered managing mental illness to be a considerable or extreme problem when working with individuals with intellectual disabilities. These findings underscore the challenges faced by direct staff members in managing psychiatric symptoms including depression, anxiety, psychotic symptoms, and compulsive behaviors among individuals with intellectual disabilities and BC. The results of the study indicated that direct staff members reported that they found managing these psychiatric symptoms to be particularly challenging. Below we will discuss the implications of the results found in this study.

Direct staff members who work with individuals with intellectual disabilities and challenging behaviour often lack training in psychiatric health specific to this population (Ee et al. 2022). This lack of knowledge puts them at risk of failing to identify psychiatric ill health and access appropriate treatment facilities (Cooper et al. 2007). The implications of this knowledge gap include the potential for neglecting individuals' psychiatric symptoms and failing to make accurate diagnoses. Additionally, there is a risk of providing incorrect or inadequate treatment, or over-reliance on psychotropic medications (Sheehan et al. 2017). Research has highlighted the importance of providing training to healthcare professionals regarding mental disorders (Knotter et al. 2016). This is particularly relevant for direct staff members who work with individuals with intellectual disabilities and psychiatric symptoms, as they often have problematic attitudes towards their clients. A study conducted in the Netherlands explored the attitudes of direct care staff towards challenging behaviour (BC) in individuals with intellectual disabilities (Neijmeijer et al. 2018). The findings revealed that the characteristics of the clients, especially their psychiatric diagnoses, played a significant role in influencing the staff members' attitudes towards aggression. These findings emphasize the need for training and education aimed at improving the attitudes and understanding of direct staff members towards individuals with intellectual disabilities and psychiatric symptoms. By providing comprehensive training, healthcare professionals can gain the necessary knowledge and skills to effectively support and care for individuals with complex needs, including those related to mental health (Whittle et al. 2018).

Spassiani et al. (2017) shed light on the experience of people with intellectual disabilities, their family members, and direct staff during hospital visits for psychiatric crises. They report that direct staff members felt that their competence was questioned and that they were expected to be able to manage psychiatric problems within the supported accommodation setting. They also expressed a sense of being seen as a burden and believed that the healthcare system had insufficient resources to adequately support people with intellectual disabilities. Furthermore, the participants reported that brief encounters with healthcare professionals often resulted in more harm than good for the residents, an outcome they attributed to hospital staff not taking

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the time to familiarize themselves with the individuals' specific needs and circumstances. These findings highlight the crucial importance of direct staff members understanding and effectively managing psychiatric symptoms and mental illness among the residents in supported accommodation for people with intellectual disabilities.

One way to educate direct staff about how to deal with psychiatric symptoms in people with intellectual disabilities and BC is web-based training in the workplace. A well-evaluated method is Oliver McGowen's Mandatory Training. The training is structured into two tiers. Tier One is designed for individuals who require general awareness of the support needs of people with intellectual disabilities. Tier Two, aimed primarily at healthcare providers such as nurses, is for those directly involved in the care of individuals with intellectual disabilities. The training covers a range of topics, including how to avoid diagnostic overshadowing, common comorbidities, legal considerations in care, reasonable adjustments such as hospital passports, the importance of annual health checks, and effective communication strategies (Evans 2023).

Web-based learning can be an effective approach as it is convenient and accessible, allowing staff members to learn at their own pace and within their work environment. The content of the training should be comprehensive, covering topics such as understanding psychiatric symptoms, effective communication strategies, assessment techniques, and appropriate actions when faced with BC. It is essential to emphasize the importance of person-centered care and of understanding the unique needs and abilities of individuals with intellectual disabilities (Pusa et al. 2019; Truong et al. 2021).

By incorporating reflection and awareness-building exercises, the training can facilitate a learning process that encourages direct staff members to critically evaluate their own values, feelings, and abilities in relation to their work with people with intellectual disabilities. This self-reflection can lead to a better understanding of the impact of the workplace culture and physical environment on the development and well-being of residents. Drawing on the experience and expertise of direct staff members themselves can be valuable in the training process. Encouraging staff members to share their insights, challenges, and success stories can foster a supportive and collaborative learning environment. This approach can also help create a sense of ownership and empowerment among staff members, leading to improved job satisfaction and the implementation of best practices in supporting individuals with intellectual disabilities and psychiatric symptoms (see Pusa et al. 2019). To ensure appropriate care and support, it is essential for healthcare professionals to collaborate closely with direct staff members, gaining a comprehensive understanding of the unique challenges and needs of individuals with intellectual disabilities. This collaboration can help improve the overall quality of care provided to this population and ensure that their mental health needs are addressed effectively within the healthcare system (Ashok et al. 2023; Sommerstad et al. 2021).

Training is crucial for increased knowledge among direct staff supporting people with intellectual disabilities (Kelley et al. 2023). It is their responsibility to demonstrate engagement, care, and genuine interest in providing sufficient support in situations of BC. By spending quality time together and showing genuine engagement, direct staff members can develop a deeper understanding of an individual's needs and challenges related to their psychiatric ill health (Molin et al. 2018). This understanding, supplemented by training, is essential for providing appropriate and effective support tailored to the individual's unique circumstances. Research studies, such as those of Andersson (2016), Barker and Buchanan-Barker (2005), and Molin et al. (2018), emphasise the importance of direct staff members' knowledge, engagement, and genuine care in supporting individuals with psychiatric ill health. Indeed, direct staff members play a vital role in supporting individuals with intellectual disabilities who experience psychiatric symptoms and demonstrate BC.

5 | Limitations

This study has looked at the experiences of direct staff members related to managing psychiatric symptoms in interactions with people with intellectual disabilities and BC in supported accommodation. It does not offer documented diagnoses or residents' descriptions of their diagnoses or symptoms. This can be seen as a weakness of the study. On the other hand, the study does set out the experience of those who meet vulnerable people with intellectual disabilities daily.

Another limitation that may have affected the identification and reporting of management difficulties is the employment status of the staff, specifically whether they worked full-time or part-time. Unfortunately, we do not have information about this. Another aspect to consider is the ability of direct staff members to identify and appropriately label psychiatric symptoms, as this is usually outside their scope of practice. Thus, it is important to allow for the possibility of over- or under-reporting when analyzing research based on the survey. Generalizing the results outside the current context is complex. The staff rated compulsive behavior as common among these residents, but it could be debated whether this can be attributed to the residents' intellectual disabilities or to psychiatric symptoms. Obsessive compulsive disorder is known to occur in patients with intellectual disabilities. Often, the intellectual disability and lack of communication in these patients make it difficult to diagnose and assess the disorder (Gautam and Bhatia 2015). In this study, it is clearly attributed by the staff to psychiatric symptoms.

The fact that 197 of the 212 staff members answered the questionnaire could be considered a positive outcome in terms of participation. However, the internal missing values were high; for example, the item rating frequency of depression had a missing value of 20%, and the item auditory hallucination had a missing value of 30%. The missing information may have been omitted because some participants assumed that the researchers were only interested in psychiatric symptoms. The reduction of the original 5-point Likert scales concerning frequencies and managing difficulties into two 3-point Likert scales can be seen as a problem. The motive was to make it easier for the reader to grasp the material. It is problematic that the extended version of the questionnaire with seven new items had not been tested psychometrically. The extended questionnaire was used in Blinded

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author and Blinded author and will likely undergo psychometric testing in future studies.

6 | Conclusions

Direct staff working with people with intellectual disabilities and BC report a high prevalence of psychiatric symptoms among these residents. However, these staff lack the necessary tools to comprehend and manage the demands of caregiving effectively. By demonstrating genuine interest and dedicating time to people with intellectual disabilities and psychiatric symptoms, we can bridge gaps in understanding and provide the necessary support. Nursing education also plays a critical role in fostering effective collaboration within the realm of intellectual disability support. Implementing web-based training for staff members in supported accommodation is an effective means of providing the required training to address the demands of psychiatric ill health. It is essential to conduct further research and evaluation to improve access to mental health care for individuals with intellectual disabilities.

7 | Relevance for Clinical Practice

This study offers useful insights into the challenges direct staff encounter when managing psychiatric symptoms among people with intellectual disabilities, emphasizing the need for specialized training and support. Our findings show that depression, anxiety, and psychotic symptoms are particularly difficult to manage, highlighting a significant gap in staff preparedness. By recommending accessible, web-based training and promoting collaboration, this study encourages enhanced knowledge and practical skills among staff, ultimately aiming to improve mental health care for individuals with intellectual disabilities in supported accommodations.

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Ethics Statement

Approved ethics applications were registered with Dnr. 355–17 Ethical Board Gothenburg University. Staff who did not wish to participate in the study or wished to cancel their participation were offered to do so without stating reasons. Questions in scales could generally be perceived as omissions and could cause concern for staff as having made mistakes in the care. In that case, the risk was considered negligible. All information collected was treated as confidential.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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