

**Patient Centred Physical Restraint:
A Case Study of Two NHS Mental Health Inpatient Wards**

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Abstract

The nursing staffs who work in the NHS mental health in-patient wards sometimes physically restrain their patients. Whilst there are studies that have looked at the different aspects of the use of physical restraint, none has specifically investigated the experiences and perceptions of the staff on the use of the patient centred model of physical restraint in managing untoward incidents in the setting.

As a trainer on the General Services Association model of physical intervention, I worked collaboratively with staff from two NHS mental health inpatient wards, users of physical restraint techniques, to explore their experiences, perspectives and indeed the effectiveness of the patient centred approach to physical restraint in their respective wards.

Following a review of the relevant literature, the choice of a qualitative type of investigation based on the unmodified Husserlian phenomenological framework was made. To complement this style of investigation, focus group and semi-structured interviews were used to collect primary data from the study participants.

Phenomenological recommendations were adopted in the analysis of data. Six core themes including: physical restraint of a patient is for safety and patient centred practices during restraint process emerged from the huge data. The findings confirmed that patient centred approach to physical restraint was effective with the patient groups in the participating wards. Participants emphatically stated that the model enabled a quick retrieval of the therapeutic relationship with their patients. This is in keeping with the ethos of mental health care which is reliant on therapeutic relationship with the patient.

Key words: In-patient wards, mental health, patient centred physical restraint, therapeutic relationship, violence & aggression

Chapter One

INTRODUCTION

1.1 Background

“Treat all service users with dignity and respect, regardless of culture, gender, diagnosis...”
(NICE 2005 p20).

But then *“...sometimes...they’re (nurses) just about able to cope themselves with the aggression”* (Moran et al. 2009 p602).

The Department of Health retracted its decision to include death and serious disability by physical restraint in the list of ‘Never Events’ or serious, largely preventable patient safety incidents (Butterworth and Harbison 2011). Nevertheless the incident ignited a debate on an important safety issue concerning restraint practices observed Butterworth and Harbison (2011). One wonders why the change of mind by the Department of Health? Did they realize, as authors such as Duxbury (2002) and Stewart, Bowers, Simpson, Ryan and Tziggili (2009) found, that physical restraint is an essential management tool especially in a psychiatric setting?

While the argument about whether there is a correlation between psychiatric disorder and violence goes on (Cornaggia, Beghi, Pavone, and Barale 2011), this study wants to concentrate on the use of physical/manual restraint to manage incidents within psychiatric in-patient wards.

Physical restraint remains the most frequently used method for dealing with untoward incidents in the health settings in the UK (Sequeira and Halstead 2004). Notwithstanding, debate on the appropriateness, in particular, the patient centeredness of this method of intervention seems to gain reactionary and short lived attention usually in response to the occasional media reports about an abuse of the method. Examples include the BBC Panorama analysing the ‘Winterbourne View’ scandal (2011) and a second report analysing ‘prone restraint’ (Mind 2013). Authors, including Winship (2006) and Ryan and Bowers (2006) emphasise the need for a sustained study on this social phenomenon particularly on its psychological effects on the individuals involved – patients, staff and observers. As found by Moran et al. (2009) and Hollins and Paterson (2009), involvement in the manual restraint of patients can affect staff physically and emotionally as it does the patients (Kumar, Guite and Thornicroft 2001, Fisher 2003, Winship 2010).

Concern for the negative effects of physical restraint has some authors advocating for curtailment (Paterson 2005, Keski-Valkama et al. 2007, Bowers, Flood, Brennan and Allan 2008, Sturrock 2010). Others, including Bond (2006) and Mind (2013) campaign for the prohibition of certain techniques. But, there are situations in the care settings when physical intervention is inevitable and may indeed save life argue Marangos-Frost and Wells (2000), Paterson (2007), Raija et al. (2010), Hollins and Stubbs (2011), DH (2014). If such is the case, then in my opinion the focus should be on how to make physical restraint as caring an intervention as possible. As observed by Winship (2006), the challenge remains that of shifting restraint away from a cold mechanical procedure to one where the conception of care and therapy is centremost in the minds of the practitioners. This is particularly relevant in psychiatric settings where, as pointed out by Outlaw and Lowery (1994), the quality of care depends on the strength of the therapeutic alliance between patients and nursing staff.

In an age when the stress of living is taking a toll on people's wellbeing particularly their mental health, anybody could become a victim of mental ill health. In fact, the news media reports indicate that young people in their twenties and thirties are increasingly vulnerable to mental illness particularly depression (BBC Breakfast News 2014). Smith (Metro 20th January 2014 Front page) calls it '*The pressure cooker generation*' describing the situation as '*sitting on a mental health time bomb*'. According to the University College Union briefing (2013) one in four people will experience some kind of mental health condition in the course of a year.

In the UK a bill to repeal areas of discrimination on grounds of mental ill health is being processed (Wykes and Craig 2013). These authors reason that the removal of restrictions that prevent people from playing their part in public life could send a wider message to the public about the way in which Parliament wants society as a whole to regard people who are struggling with mental health problems including the way we care for them. As posited by Parahoo (2006), frameworks for interpreting phenomena change in response to the evolving ontological and epistemological stances in society. This Parliamentary effort will legitimize and hopefully give impetus to calls for service user oriented approaches to care, particularly during a physical restraint process (BILD 2001, Tew, Gell and Forster 2004, NIMHE 2004, DH 2006, McCormack and McCance 2006, NICE 2015). The Human Rights Act (1998) and its accompanying litigious climate (Noak et al. 2002, Hollins 2010) no doubt help to instil caution into professional practice making it even more compelling for the philosophy on patient restraint to be clearly outlined (Barber, Brown and Martin 2009).

I work within a team that facilitates training on the therapeutic management of aggression and violence for health care professionals. The model of physical restraint, the General Services Association (GSA) model taught by my team have their roots in Martial Arts and were originally pain compliant (Wright, Sayer and Par 2005; Roger, Miller and Paterson 2007) based on the belief during the early days of the model that the greater the pain the staff restraint team could inflict on the restrained individual, the quicker they would gain compliance. When however evidence showed that inflicting pain did not necessarily gain compliance, that in fact it could induce greater resistance (Blofeld 2003) the techniques were modified and became 'non-pain compliant' (Paterson 2007, The GSA 2009). My team passionately lay emphasis on patient care during physical restraint evidenced by the involvement in the team's training delivery of local mental health service users who themselves have had the experience of being restrained (Obi-Udejaja, Crosby, Ryan, Sukhram and Holmshaw 2010).

1.2 Rationale for the study

To help improve my team's training service, I carried out a study on the experiences of mental health service users whilst being restrained in local NHS inpatient wards (Obi-Udejaja 2009 Title page). A finding from the study indicating that when physical restraint was carried out in a caring manner, the service users viewed the experience as positive and staffs were able to reasonably quickly regain the therapeutic relationship with the service users prompted further interest in the phenomenon. The finding drives this study which seeks to explore the views of the staffs in the care sector who are involved in incidents that are managed using physical restraint. Research evidences show that such views are rarely explored (Forster, Bowers and Nijman 2007). Yet, such exploration is essential in order to continually improve the physical restraint process and make it effective, efficient and acceptable to those involved. This study focuses on the patient centeredness of physical restraint ((definition 1.6.3) as used within the inpatient setting. It seeks to find out staffs' perspectives - their subjective experiences, perceptions, actions and inactions before, during and after the restraint process. The outcome will hopefully provide a fuller picture of the phenomenon and enable further improvement of my team's training service.

1.3 Aim of the study

The study aims to work collaboratively with mental health ward staff members to identify understandings, experiences and perceived barriers of patient centred physical restraint.

1.4 Objectives:

Explore the ward staff members' perspectives on patient centred physical restraint

Determine whether the approach works effectively with mental health inpatients

Identify barriers to patient centred practices during physical restraint procedures

Propose changes if necessary to make the approach sustainable in the setting

1.5 Research Question

How effective and sustainable are patient centred manual restraint practices in mental health inpatient wards?

1.6 Operational Definitions:

1.6.1 Physical restraint

For the purpose of this study physical restraint is defined as any incident in which the staff physically lay hands on a patient; to hold, guide, restrict or prevent movement.

1.6.2 Mechanical restraint

This differs from physical restraint in that some form of device e.g. arm splint/ restraint vest, is used to achieve restraint, Mechanical restraint is not considered as it is not commonly used in the UK.

1.6.3 The GSA model of physical restraint training

The National Institute for Health and Care Excellence (NICE 2015) issued guideline on violence and aggression: short term management in mental health, health and community settings intended to improve skills of staff in dealing with potentially aggressive and violent situations to ensure that they can be prevented or managed in a safe and therapeutic manner. The guideline provides a framework for dealing with violent situations before, during and after they occur, with emphasis and specific guidance on prevention and de-escalation through to safe interventions and post-incident de-brief.

The GSA training is modelled along the NICE frame work. It comprises theoretical and physical components. The theoretical component lays emphasis on prevention and de-escalation achieved mainly through observation and effective communication. The physical

component boasts of a hierarchy of holds that runs from low-level to high-level. Staffs are thus able to match the level of the patient's agitation with the appropriate hold. The effort to de-escalate the situation is ongoing throughout the process. It is known that such an effort yields quicker results when the hold is appropriate which is in keeping with the philosophy of patient centred approach defined below and promoted by my team's training.

1.6.4 Patient centred physical restraint

The term 'patient centred physical restraint' in the context of this project, is defined as a restraint process in which the patient's physical, emotional and other ethical needs are catered for right through the process in line with the four principles of 'person centred care': affording people dignity, compassion and respect; offering coordinated care, support or treatment; offering personalised care, support or treatment and being enabling (The Health Foundation 2014).

Manual restraint and physical restraint are used interchangeably to mean the same thing.

1.7 Scope of the study

This research is concerned with the short term management of violence and aggression. Its focus is on the intervention by the staff at the build-up stage, the use of physical intervention at the crisis stage and what happens when it is over (debriefing) as depicted in figure 1.

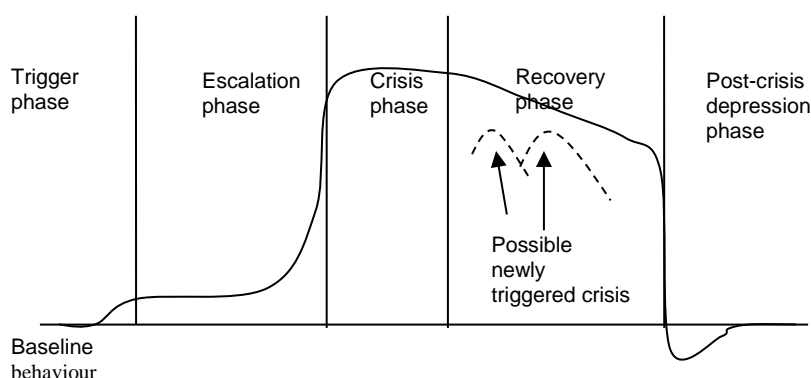


Fig. 1: *Phases of a typical assault cycle adapted from Kid and Stark (1995, p8)*

The importance of long-term therapeutic management approaches to reduce incidents of violence and aggression in inpatient wards is acknowledged. However, such approaches are beyond the scope of this study.

1.8 Conclusion

The aims and objectives of this study have been explained above.

Chapter two explores the existing literature on the use of manual restraint in managing untoward incidents in the health sector with particular focus on the NHS mental health in-patient wards.

The approach adopted for the study is explained in chapter three.

The findings from the data analysis are presented in chapter four.

Chapter five critically discusses the summary of the findings, drawing on the reviewed literature and on the study participants' responses.

Chapter six contains the overall conclusion, the recommendations as well as the contribution to practice claimed by the study.

Chapter Two

LITERATURE REVIEW

2.1 Introduction

Physical restraint remains a controversial management tool for untoward incidents giving rise to widespread concerns regarding the possibility of abuse (Allen and Harris 2000). The concept of manually restraining a person automatically brings to mind documentaries of some high handed restraint techniques or abusive methods of taking control of an individual that sometimes result in injuries or even death as in the deaths of David [Rocky] Bennett (1998) and Gareth Myatt (2004). Hardly does it come to mind that the procedure could be caring and in the best interest of the recipient.

In the UK, front line workers such as police officers, prison officers and health care workers who use physical restraint at some instances in their jobs seem to have differing philosophies regarding the use of the tool. Such philosophies one assumes are determined by their type of clientele and justified by the underlying reasons and the presenting behaviour. For example, the police might be dealing with aggression/violence from individuals under the influence of alcohol and/or drugs. Their resort to restraint is often described as '*police use of force*' (Klahm IV and Tillyer 2010 p.230). The prison officer might be dealing with frustration induced violence from the inmates. Their model of physical restraint could be seen as high handed (The Lord Carlile of Breriew QC 2004).

The health care practitioners confronted with aggression/violence from their patients either due to factors internal to the patients such as their illness or external such as the hospital environment or indeed their interactions with the practitioners (Duxbury 2002, Sturrock 2010) are expected to adopt a caring/patient centred approach in their use of the restraint techniques. Their model of physical restraint, most versions of which have evolved from the prison model is described using various terms that signify effort to break links with its earlier pain compliant background.

This work will start by critically evaluating relevant literature and justifying the need for the study.

2.2 Literature search strategy

The Cinahl (Cumulative Index of Nursing and Allied Health), Medline (Medical Literature Analysis and Retrieval System Online), British Nursing Index, PsychInfo (American Psychological Association), Google Scholar, as well as the Middlesex University Repository were searched to find studies that specifically explored patient centred physical restraint in mental health inpatient wards. Key search terms included: violence and aggression, NHS settings, mental health wards, physical intervention, patient centred restraint, staff perspective. Based on these searches and other efforts to locate prior studies on the topic, it was evident that little research work had been carried out that looked specifically at patient centred approach to physical restraint, in particular staff experiences and views on the use of the model.

Further searches were carried out to locate related studies on the topic. The outcome was more encouraging. Relevant materials circulated via e-mail by work colleagues, dissertation abstracts and conference presentations were added to the list. A total of thirty seven articles were logged and classified. Published books were consulted for further information.

The review process was guided by methods suggested in the research texts such as Bell (2005). I critically examined and analysed each item of literature visually searching for and pulling together themes and issues that were associated and relevant to my angle of investigation. These were categorised. A total of five key themes were identified.

The discussion on the contents of the published papers was carried out under the themes including:

2.3 Reasons for patients' aggression

Authors who have looked at reasons for aggression in inpatient settings identify various and often differing views from patients and staff.

Using a 'Management of Aggressions & Violence Attitude Scale' Duxbury and Whittington (2005) found that patients saw environmental conditions and poor communication as significant precursors, whereas staff in the same study viewed the patients' mental illnesses to be the main cause. In line Sturrock (2010), using a literature review identified communication failures and other interactional problems between patients and the nursing staff as antecedents for patient aggression leading to physical restraint. The staff participants in Bonner, Lowe, Rawcliffe and Wellman's (2002) qualitative interviews agreed with these views identifying

poor ward atmosphere and failed communication with their patients as reasons for aggressive incidents requiring the use of restraint procedures.

Invariably, care settings that share similar views to staff in the Duxbury and Whittington (2005) study above tend to adopt the medical model approach to practice where patients' behaviours must be controlled by whatever means including physical restraint. This is in line with Marangos-Frost and Wells' (2000) observation in their ethnographic research that the philosophy of the unit influences their approach to practice. A unit with medical-model orientation, the dominant model in society in any case, considers any patient's untoward behaviours as symptoms of their illness that should be controlled even if by the use of restraint thus legitimizing overreliance on physical restraint (Kumar et al. 2001). Reiterating, Bowers et al. observed in 2007 that carers with positive attitude towards people with mental health problem find it easier to manage their emotional reactions than those with negative attitude who would readily resort to coercive methods such as physical restraint.

Kontio et al. (2010) noted little or no spontaneous discussion between their focus group interview staff participants regarding aggressive patients' feelings. One wondered whether that was due to outright disregard, negligence or insensitivity on the part of those staff. Interestingly the same study did establish that older, well-educated and experienced nurses were better able to recognise early signs of aggression and to intervene appropriately, sensitively and effectively. The study however warned against the weakness of practice based on habits and culture which could impede development particularly where there is a reluctance to try new ways of practice.

Differing from the above view-points, Ryan and Bowers (2006) using content analysis of post-incident reports, found that the use of manual restraint was more related to patients' ill-directed frustration, resistance to containment and their desire to leave the ward. Meanwhile, both patients and staff in studies including Duxbury (2002) unanimously acknowledge the negative impact of the in-patient environment.

Using a Staff Observation Aggression Scale Foster et al. (2007) concluded that fear generated from working in an aggressive environment coupled with difficulty in understanding the causes of patient aggression may motivate staff to manage aggressive incidents with coercive methods such as restraint. This emphasizes the need for training on understanding patients' aggression and how to prevent or manage it, and indeed for more research on the topic.

2.4 Is restraint inevitable?

The definitions of physical restraint seem to reflect the conflicting perceptions of the phenomenon (Moran et al. 2009). While some define it as any incident that makes it necessary for staff to lay hands on a patient (Bonner et al 2002) therefore an all-inclusive management tool, others including NICE (2005) associate it with violent incidents only. Not surprisingly therefore some people see it as all about violence, while others appreciate its hierarchical nature that makes it adaptable for different needs of the recipient.

Winship (2006) throws light on physical restraint as operationally defined in this study when his essay looks at the phenomenon in its variant forms necessitating the adaptation of its hierarchy of holds as called for by the presenting situation. So, it could be low level such as guiding/steering holds for elderly persons with problematic mobility or high level intervention for a very psychotic patient who needs to be protected from different types of harm. Winship (2006 p.55) further referred to '*caring restraint*' as an element of everyday human interaction in nursing and identified the absence of an inclusive definition of the spectrum of restraint in the 2005 NICE guideline as a shortcoming of the document.

The service users in Guilburt et al. (2008 p9) a participatory research approach incorporating in-depth interview laid emphasis on what they termed '*the feeling of safety*'. According to this finding, an experience of safety was maintained despite fearful situations arising, when staff demonstrated professionalism in their job and were able to control and contain situations, preventing them escalating and affecting other patients. Staff and patients in Duxbury (2002) and Duxbury and Whittington (2005) echo this finding. They perceive restraint as inevitable and needed in order to maintain safety, a claim that is hotly disputed in Martin et al's (2008) review of published papers which was unable to confirm an association between patient safety and physical restraint. Meanwhile, in his review of the legal and ethical implication of using the restraint tool, Beech (2001) made it clear that from the civil law perspective, it could be negligence (failure to observe a duty of care) not to restrain. Notwithstanding this legal view, there are studies that question the ethical morality and effectiveness of the use of physical restraint. In particular, studies that identify nurse-patient interactions as a significant precursor to aggression question the use of physical restraint as an acceptable therapeutic intervention (Irwin 2006). Whereas the staff participants in Bigwood and Crowe (2008) and Kontio et al. (2010) express a feeling of frustration and guilt when unable to find alternatives to the use of restraint, a number of other researchers share similar findings as Guilburt et al. above including:

Bonner et al. (2002), Stewart et al. (2009) and Larue, Dumais, Ahern, Bernheim, and Mailhot (2009).

In the management of aggression, nurses' attitude towards aggressive behaviour will influence their clinical behaviours and choice of intervention (Needham, Abderhalden, Dassen, Haug and Fischer 2004, Patterson, McIntosh, Wilkinson, McComish and Smith 2012), and those actions will determine the therapeutic value of the intervention (Irwin 2006). Larue et al. (2009) reinforce the need for a systematically managed restraint process that completes its cycle including the post incident follow-up which enables a reflective review of the problem-resolution process.

2.5 Perceptions and feelings about restraint

Studies that explore the staffs' and/or patients' views regarding physical restraint as used in inpatient wards have much to say about its emotional effects on both parties. Similar to the differing views regarding the reasons for aggression and violence, patients and staff hold variant perspectives about the effects of physical restraint influenced no doubt by their subjective experiences of it.

Using a qualitative research approach incorporating focus group discussions Moran et al. (2009) note that the controversial nature of physical restraint creates a complex dilemma for the nursing staff which initiates emotional distress. Marangos-frost and Wells (2000) use the term 'the conflicted nurse' to describe the nurses struggling with their sense of duty to protect others and their professional, legal and ethical responsibility to protect the aggressive patient. "*It's part of the job, but it spoils the job*" summarised the staff participants in Bigwood and Crowe (2008 Title page). Papers including Sequeira and Halsted (2004) talk about the feelings of anger and emotional distress shown by patients prior to the restraint incident and then disgust and embarrassment for stooping so low after the restraint. Bonner et al (2002) and Hollins (2010) observe that staffs mirror many of the patients' feelings in addition to their feelings of anxiety and fear. A staff participant in the study by Bonner et al (2002) said that he was so terrified that he wetted himself. On how this feeling of fear impacts on the quality of patient care, Moran et al (2009) and Forster et al. (2007) conclude that the resultant emotional detachment would negatively affect the therapeutic relationship between nurse and patient. This runs contrary to the essence of psychiatric nursing that depends on connected relationship based on empathy and trust (Bland et al. cited in Moran et al 2009). Meanwhile, a participant in

Sequeira and Halstead (2004) described how witnessing physical restraint affected her mother who had visited at the time saying that her mum's face turned '*whitey grey*' with fear (Sequeira and Halstead 2004 p.6).

Participants in Bonner et al. (2002) talked about how their experience of restraint re-ignited their previous experiences of abuse. Women participants in this study expressed anger at having male staff restrain them for intramuscular injections. Similarly, in Obi-Udeaja (2009) a female service user study participant stated that she could not accept care from any of the members of an all-male restraint team that held her down for an intramuscular injection during her admission and that she felt like committing suicide after she left the hospital. Another female participant in the same study said that she felt a consuming humiliation when she was restrained and carried as if on a stretcher in a public area (Obi-Udeaja 2009). Meanwhile, featuring very strongly among the numerous recommendations from the Blofeld (2003) enquiry on the death of David [Rocky] Bennett whilst he was being physically restrained, was that organisations should ensure to reflect adequate mix within their staff that would enable them meet the needs of their service users. Equally, NICE (2005) guideline on the short-term management of disturbed/violent behaviour in psychiatric in-patient settings had implored that all service users would be treated with dignity and respect regardless of culture, gender, diagnosis, ethnicity etcetera. Reiterating, the latest edition of the guideline lays out principles for improving service user experience especially when managing incidents of violence and aggression which among other things include ensuring their safety and dignity, training staff in cultural awareness and in gender awareness especially when carrying out searches (NICE 2015).

It is worth noting that some of the reviewed papers talked about positive outcomes of restraint (Steckley 2008, Stewart et al. 2009) and its calming effects (Wynn 2004).

2.6 Training

Most of the papers reviewed talked about training, some more elaborately than others, depending on their focus point.

Using semi-structured interviews, Jones and Stenfert Kroese (2006) found among other things that there is a definite need for staff training for those involved in restraint practices, a view echoed by many including Noak (2002), Stewart et al. (2009) and emphasised by NICE (2015).

Training should be core skill for frontline staff they say. Service user participants in Jones and Stenfert Kroese (2006) acknowledged this need when concern for injuries due to poor proficiency and training was discussed. A patient in the study had retorted that if staff could not handle restraint then they should not be working in the establishment (Jones and Stenfert Kroese 2006). The ability of the staff to prevent incidents escalating and affecting others gives a sense of safety reiterated the service user participants in Gilbert et al. (2008).

Many of the authors believe that focusing mental health nurses' training on improving methods of communication would enhance nurse-patient relationship and help to proactively identify causes. This in turn would minimize incidents and reduce the use of coercive interventions such as physical restraint (Irwin 2006, Foster et al. 2007, Jonker, Goossens, Steenhuis and Oud 2008, Bjorkdahl and Palmstierna 2013). Meanwhile, a patient in the Duxbury and Whittington (2005) study had remarked that he didn't think that anyone trained the nurses on how to deal with people.

In his review of literature, Stewart et al. (2009) found that injuries from manual restraint were generally more common among staff than patients; no wonder that staff hold those emotional feelings of fear and anxiety. There is a need therefore for comprehensive and adequate training that would enhance staff confidence in dealing with challenging situations (Larue et al. 2009).

2.7 Patient centred practices during physical restraint

"If all do their duty, they need not fear harm" (The Lord Carlile of Breriew QC 2004 Title page).

Kontio et al. (2010) very pertinently ask what actually happens with an aggressive patient on the ward and what alternative methods are available in normal settings? In their opinion, these are ethical issues yet to be explored in sufficient depth.

Authors, including Marangos-Frost and Wells (2000) and Sequeira and Halstead (2004) talk about the conflicted nurse who believes it is her duty to protect others including the aggressive patient and who perceives restraint as in conflict with this role. A number of papers including (Foster et al. 2007, Martin et al. 2008, Sturrock 2010) appear to have the solution to the nurse's dilemma by suggesting what they term 'alternatives' to restraint involving 'non-touch' interventions (Brennan 1999) and holding the patient until he calms down. One assumes that the method of holding suggested here is the same as what Winshisp (2006 p55) terms '*caring*

restraint' or therapeutic holding based on the understanding of the underlying psychological dynamics of the event. As I perceive it, this understanding is crucial and determines the fine line between caring restraint and restraint perceived by the patient as punishment (Kumar et al. 2001). Reinforcing, Irwin (2006) and Kontio et al (2010) highlight the importance of knowledge of the patient or a relationship centred on trust for achieving a 'patient centred' restraint. Such relationship promotes listening and maintaining communication with the patient during the restraint process which practice ensures maximum humanity possible and that all ethical needs are catered for (Beech 2001, Sturrock 2010).

Some of the papers talk about the importance of debriefing people involved in restraint including observers (Stewart et al. 2009, Kontio et al 2010). There is concern that this aspect of physical restraint is not a common practice (Irwin 2006). Sturrock 2010 however warns against debriefing too soon after the incident. According to him, people need time to reflect on the experience. Stewart et al. (2009) and Moran et al. (2009) talk about the need for clinical supervision/support for nurses that in their opinion would help them to manage the emotions generated by involvement in physical restraint and to improve practice.

2.8 Conclusion

The review shows that there is dearth of study specifically on the patient centred model of physical restraint. This gap needs to be filled. Equally, the divergent views and the accompanying concerns about in-patient restraint as exposed in this literature review underscores the need for further research on the phenomenon in order to find an effective and unanimously acceptable model of the physical restraint techniques.

The next chapter will discuss the ways that were used to:

- Collect data from the study participants who were involved in hands-on patient restraint in the study wards
- Collect data from the ward managers who co-ordinated the restraint process in the study wards

Chapter Three

RESEARCH METHODOLOGY

3.1 Introduction

This chapter will attempt to explain how the study was undertaken, the choice of research strategy driven by my ontological and epistemological assumptions (Grix 2004). Issues discussed include: the conceptual approach, the methods used and their justifications, the data collection techniques, their limitations and the ethical considerations during the process as well as issues of reliability and validity of the data.

3.2 Research approach and design

The issue of interest in this study was a social phenomenon – the use of physical restraint to manage incidents involving mentally ill patients. Lukose (2011) claims that it falls under the academic discipline of nursing studies a caring science which implies close interaction between the carer and the care receiver. The question was, what approach was best suited for this kind of study - a ‘detached’ or an ‘interactive’ stance? In deciding which strategy to use, I considered that if one wanted to get a true picture of what happened in each restraint scenario including the feelings of the study participants regarding the experience, then it was necessary to get close to the data source in line with interpretivism (Crotty 1998, Gray 2004).

With this in mind, I believed that a constructionist philosophy in which an individual engages with objects in their world to make sense of them could yield more reliable information on the phenomenon than objectivism whose stance is that reality consists of what is observable (a detached stance). I needed to interact closely with the staff members in order to understand their restraint practices, as they in turn engaged with, re-examined and tried to make sense of their actions/inactions from the point of view of sensitivity to patients’ needs during restraint procedures in which they participated. Smith and Osborn (2003) refer to this as a double Hermeneutic approach.

In line with these ontological and epistemological perspectives, phenomenological philosophy was considered the appropriate framework to help examine and recognise these lived experiences (ward physical restraint incidents) that were often taken for granted. This choice was on the basis that more reliable information could be gained by critically examining the

staff restraint practices and their explanations of such practices from the point of view of sensitivity to patients' wellbeing during the process. As implied by Crotty (1998), different ways of researching the world shape different ways of viewing it.

To complement this framework, a phenomenological research strategy based on a collaborative style of investigation where ward restraint staff members were actively involved in the field work was employed. Other methods, in particular, Action research were considered but viewed as unsuitable because I was an 'outsider' to the ward. Action research is known to be better suited to facilitating changes in selves rather than in others (Fox, Martin and Green 2007).

The unmodified Husserlian phenomenological methodology (Crotty 1998) is qualitative in nature and in line with my stated ontological and epistemological positions. It aims to generate a description of a phenomenon of everyday experience to achieve an understanding of its essences. The goal was to gain knowledge and insights about physical restraint practices (the phenomenon) in the study wards and in so doing to add to the body of knowledge. This taken for granted 'part of the nursing job' became a phenomenon because we questioned its patient centeredness. And to understand it, Husserl recommends that we must assume an 'open mind' attitude in which prior assumptions are bracketed. Meanings and relationships are thus freely clarified through descriptions of the experience. It is argued that 'bracketing' defined as the suspension of preconceptions, prejudices and beliefs so that they do not interfere with the descriptions and interpretations of an experience (Parahoo 2006) is futile. In my view, stepping back in order to critically analyse actions is a familiar approach to everyday life issues. Schon (1983) and Bond (2006) refer to such an exercise as reflecting on action.

3.3 Rigour in qualitative research

The need for rigour in the research process calls for a comprehensive audit trail of research activities (Yardley 2008). Triangulation, defined in surveying as a method of locating where something is by getting a 'fix' on it from two or more places (Robson 2002) was considered an effective method for achieving rigour in this study. Hence, in addition to the triangulation of methods (focus groups and semi-structured interviews), the triangulation of sources was employed. This was to enable a deeper and wider understanding of the phenomenon by viewing it from different perspectives i.e. from staff members who carried out the restraint process and from the key staff who instigated, coordinated and monitored the procedure.

The study sample was based in two different mental health wards where restraint was regularly used. These wards were located in different NHS hospital sites (place triangulation). The intention was to achieve a wider representation of the study population (Sim and Wright 2000, Kumar 2005, Langdridge 2007).

While a very experienced focus group moderator, a Professor in mental health and an experienced researcher facilitated the focus group sessions, my colleague and I took notes separately. The notes were used to compare and to back up the data. The coding and categorization of the data were done independently by me and two other colleagues one of whom was a research specialist.

As stated, the investigative approach was qualitative. Proponents of quantitative method argue that qualitative method lacks validity which refers to the accuracy of what is being measured including the accuracy of information and data interpretation (McCabe and Holmes 2009). My response is that rigour in qualitative research process demonstrates validity. In this study, validity was constructed step by step (Crescentini and Mainardi 2009) through the self-critical theme of reflexivity defined as sensitivity to the ways in which the researcher and the research process shape the data collected, including the role of prior assumptions and experience (Pope and May 2006, Coolican 2009). As a trainer, I held some preconceptions regarding physical restraint of the mentally ill. Reflexivity enabled me to monitor my subjectivity and impact on the study and on the participants (Savin-Baden 2004). As observed by Bowling (2002) what we see depends on what we look at and what our previous experiences have taught us to see.

3.4 The worker Researcher

My choice of phenomenological methodology incorporating interview methods entailed close interaction with study participants. Managing such a setting had its challenges. Many issues were at play including power asymmetry (Hamberg and Johansson 1999), preconception and bias (Parahoo 2006). I had to interview individuals whom I trained and assessed regularly. Did they feel able to talk honestly? I considered that my preparation for the interview could go a long way to easing tension. I worked to ensure that the rapport (Coolican 2009) that I had with the participants over the years of training them was maintained during the field work.

My knowledge of the subject and adherence to non-pain compliance restraint philosophy (GSA 2009, NICE 2015) for example could result in a fixed perception of an ideal restraint procedure.

Nothing could destroy relationships in this kind of process more quickly than a lack of understanding and judging staff restraint practices out of context. Yardley (2008) highlights the importance of sensitivity to context. Campbell and Scott (2011) reiterate the need to understand the context of lived experience. I managed the duality of my roles (trainer/researcher) carefully and reflexively. I acknowledged and respected the change of roles during the field work believing that my outsider position would enable a fresh, neutral, macro and holistic rather than myopic view of issues in the field.

Striking a balance between job role and research was among the greatest challenges that I had to deal with particularly in the face of severe shortage of staff within my team. On reflection, I thought that the constant interruption of my research activities had both positive as well as negative impacts. Whilst I was able to reflect and come up with better ideas on how to improve and progress the study during such time out, it was extremely hard to regain the momentum and the flow when the break was long.

3.5 Preparation for the field work

Certain activities were carried out before data was collected from the study participants. These included:

3.5.1 Ethics

I needed permission from both the National Health Service and Middlesex University to carry out my investigation. I sought and obtained approvals from the NHS Research and Development Department (Appendix E) and from Middlesex University Health Studies Ethics sub-Committee (Appendix F).

3.5.2 Confirmation of the Study Wards and Sample

A study sample is the proportion or subset of the total number of units (the population) from which data can potentially be collected (Parahoo 2006). For this project, the population was all the Local NHS mental health inpatient staff who accessed my team's prevention and management of violence and aggression physical restraint training. And, the study samples were the proportions that actually participated in or coordinated the physical restraint of patients in their respective wards.

While waiting for the ethical approval, I used the lull to meet with and confirm my study wards. I contacted and visited the identified wards. They were happy to participate. I adopted this approach in acknowledgement and respect of their right to accept or to refuse to participate. I considered that it would have been disrespectful to just walk in with the approval letter from the Research and Development Department. Such an action could have evoked a feeling of resentment as the wards could have felt that participation in the project was imposed on them.

3.5.3. The study Wards

The first of the two wards was a very busy twelve bed (always full) psychiatric intensive care unit (PICU) which specialised in treatment and assessment. It was an all-male ward for individuals with bipolar affective disorder or schizophrenia with mood swings that could not be managed in open wards because of high risk of arson, aggression, damage to properties, absconding with known risks, example risks to self and others. The staff comprised a mixed gender team with an equal ratio of qualified to unqualified staff, most of who had ten or more years of experience working in the setting.

The second was an all-female very busy (always full) twelve bed treatment and assessment acute ward. The presenting condition was any form of mental illness in its acute state. The ward team contained a mix of gender of qualified and unqualified staff with at least four years of nursing experience.

For the semi-structured interview, the target number of participants was three. The size was intentionally kept small because of the time consuming nature of the analytical process (Langdrige 2007, Smith 2008). The inclusion criteria were key staff in the participating wards that instigated, coordinated and monitored restraint procedures in the wards and who had held the position for not less than one year. These individuals were usually not physically involved in hands-on restraint. As such, I reasoned that their angle of vision might help to fill in gaps that might be left from the focus group sessions and lead to a greater understanding of the phenomenon.

The decision to carry out the study with these wards was based on the fact that they were the most likely to encounter incidents that would require physical restraint as a management option.

According to Krueger (1994), eight to twelve participants is the recommendation for focus group sessions. I planned for a six staff member session for each ward. This was to allow for staff shortages in the wards.

Table 1: Study Wards and Samples (Plan)

Ward	Focus Group	Role	Semi-structured	Role
1	1 group x 6 staff	Restraint hands-on team members	1 key staff	Instigating & coordinating restraint process
2	1 group x 6 staff	Restraint hands-on team members	2 key staff	Instigating & coordinating restraint process

Having confirmed the study wards and samples, I began to prepare for the data collection process.

3.5.4 Interview questions

I prepared what I termed “Guiding Interview Questions” (Appendices A1 and A2) which were vetted by my colleagues. The idea was to use these in conjunction with other prompts to maintain a flexible structure and to steer the interview back on course when a deviation occurred.

3.5.5 Pilot Study

A trial run of data collection tools from my experience helps to expose problems that may occur in the field. Taking advantage of my worker researcher position I asked the Trust’s mental health wards staff members during their physical restraint refresher course. They kindly and voluntarily agreed to pilot the data collection tool for me (Parahoo 2006). Care was taken to recruit staff for the pilot study from wards other than those participating in the field work. The recruited individuals worked in similar wards as those who provided the actual research data and regularly encountered similar untoward incidents that needed to be managed using physical restraint. The outcome was very helpful suggestions including the need for further clarifications of the interview guide questions and to adjust the timing for the interviews. I had allowed an hour for each interview. The pilot study which was undertaken two weeks before the first actual interview session indicated that forty minutes was approximately adequate for each session. Critically considering how long it took them and the pressure of time in the wards, the pilot participants had suggested an average of forty to forty five minutes for the interviews. All the suggestions were noted and the interview schedules were fine-tuned accordingly.

3.5.6 Interview venue

All the interview sessions with the exception of one of the semi-structured interviews took place at the participating wards' venues. The arrangement for interview dates took several e-mail correspondence (Appendix B) and of course a number of cancelled appointments.

3.6 Data collection

Suggestion was made by a senior officer in the NHS Research Department not to ask for person specific information from the study participants in order to simplify access to them (Appendix G). Table 2 shows the information gathered on the study wards and participants. Pseudonyms were used in place of the participants' real names.

Table 2: Study Wards' and Participants' Information

Wards	Focus Groups	Focus Groups interview participants	Semi-Structured interview participants	Gender	Employment Status	Qualification (Mental health nursing)
1	Focus group1	ALICE	MOSES (ward manager)	female	All full time	qualified
		PETER		male		qualified
	Focus group 2	ROSE		female		qualified
		EVAN		male		unqualified
			male	qualified		
2	Focus group3	FLORENCE	JOY (ward manager)	female	All full time	qualified
		NICKY		female		unqualified
		STEVE		male		qualified
	Focus group4	ZOE		female		qualified
ANDY		male	qualified			
			female	qualified		

The following methods which complemented the chosen methodological strategy for this study were used to collect data from the participants:

3.6.1 The Focus group interviews

A focus group collects qualitative data by engaging a small number of people in an informal group discussion focused on a particular topic or set of issues (Wilkinson 2008). It uses group dynamics to stimulate discussion, gain insight and generate ideas to pursue issues in greater depth (Kitzinger 1995, Bowling 2000, Pope and May 2006). Curtis and Redmond in 2007 claimed that the non-directive nature allowed participants to comment, explain, disagree, and share attitudes and experiences.

Focus group interview was deemed suitable in view of the aim of the study (1.3) and the settings as described (very busy psychiatric intensive care and acute wards). Time was a big factor in the daily activities of these wards. This method enabled quick collection of data on participants' restraint experiences and practices (Wilkinson 2008). Additionally, working in a group helped to trigger memories as observed during the interviews.

The experience of violence and participation in a restraint process could be traumatic. Discussing the experience in a group and with others who shared similar experience may have lessened the negative effects of such recall.

The fact that confidentiality was compromised might have been an issue for some participants (Polit and Becks 2008). This was combated by including confidentiality on the list of 'House Rules' during the sessions and by using pseudonym to identify focus groups and participants (Table 2).

Arranging for the focus group interviews was a big challenge because various people were involved including the study participants and their managers, the facilitator of the sessions and my colleagues who were keen to play some roles during the interviews. I had to liaise with and coordinate all involved in order to find the time that suited everybody (Appendix B).

On the first focus group interview day, my colleagues including the facilitator and I went to the venue (the ward). We were welcomed and settled into the interview room with comfortable seats ideally positioned for easy interaction. Numerous activities appeared to be going on in the

ward. Subsequently the manager came to explain to us that the ward was struggling with staff shortage and that it was not possible to provide six staff for the interview as planned. She could only manage three staff for the day. Her suggestion of two interview sessions with three staff in each session was accepted with thanks. I apologized for the inconveniences to the ward.

I introduced my colleagues and proceeded to explain the project and the plan for the session to the participants. They were then given the information sheet (Appendix C) to read after which they were given the consent form (Appendix D) which they all signed voluntarily. The participants were reminded about their right not to answer a question if they did not wish to and the right to withdraw at any time without explanation. Permission was sought to set up two audio recorders and for me and my colleagues to take notes of the interview. The participants had no objections with any of these requests.

The atmosphere was very relaxed. The change of roles was obvious at this stage. Whereas at the training venue I was an insider and in charge when these ward staff attended my training, here in their wards, the reverse was the case. I respected this change. Obviously, the cordial relationship over the years of training and annually updating them enabled a rapport that contributed to the success of the interviews.

Taylor and Bogdan (1998) suggest the use of non-direct questions early in a qualitative interview to establish rapport and relax the participants. The facilitator adopted this approach and very quickly gained the interest and full attention of the participants. Whilst taking notes, I intently listened to and observed the dynamics as the response of one participant seemed to trigger memories for others, giving the impression of a family that have shared experiences. This is arguably a great advantage of a focus group session and a strong reason why I adopted it. Physical restraint is a team work and one that can evoke emotion. The recall can be traumatic. By recalling the experience together, these participants appeared to remember more as well as gain support from one another. The exercise may indeed have helped them to address the negative memories of the experience once and for all. Notwithstanding, I was also prepared to offer other support including one to one counselling, should it be required by any of the participants.

The session lasted for forty five minutes. There was no incident in the ward and so there was undivided attention from the participants. My colleagues and I were very satisfied with the liveliness of the session and thought that the material was very rich. The focus group interviews at the second ward ran similarly to the first. Although a six staff interview was

agreed, shortage of staff meant that the manager could only provide two staff at a sitting. Two sessions were run, each for forty five minutes.

3.6.2 The semi-structured interviews

Semi-structured interview was considered appropriate in this context because it was consonant with the phenomenological perspective and well suited for the exploration of the experiences, perceptions and opinions of the ward managers on the subject matter (Campbell and Scott 2011). The flexible nature of the method enabled probing for more information, clarification of answers and meanings which these key players in ward physical restraint ascribed to it (Kumar 2005, Pope and May 2006). Their contributions enabled further insight into the phenomenon.

I considered that these individuals might prefer the privacy afforded by semi-structured interview to reflect on restraint scenarios and that they might feel safer talking about incidents rather than committing them to writing as would be the case with for example, questionnaire method. An obvious disadvantage of semi-structured interview was non-anonymity. This was addressed by anonymizing the transcripts (Robson 2002).

The face to face interaction required in an interview came with benefits as well as limitations. Whilst providing the opportunity to observe non-verbal cues which might hold messages that could help in understanding the verbal responses as noted by Robson in 2002, it raised the issue of research bias (Polit and Becks 2008). Throughout this study, I tried to minimise bias by continually questioning my practice and adopting a critical attitude towards the data interpretation (Gray 2004).

I personally conducted the one to one interviews. For each interview, I developed a specific interview schedule that tried to fill any gaps from the ward's focus group interviews. The first of the interviews was held in the manager's office. I arrived in good time to relax and set up for the session. The manager had to make a long telephone call in order to sort out an urgent matter. I waited patiently and reassured her that the ward's needs should take priority. When she was ready, I gave her the information sheet followed by the consent form which she completed. As with the focus groups, I sought her permission to use the tape recorders. In line with Taylor and Bogdan's (1998) suggestions, I started the session with general questions as a warm up with an aim to relax the manager and to establish a rapport.

Robson (2002) opined that the quality of a flexible design study depends to a great extent on the quality of the investigator. Such personal qualities as an open and enquiring mind, being a good listener, being sensitive and responsive to contradictory evidence are essential. I made a special effort to bear those in mind during the interviews. The manager spoke in a relaxed manner. I intently listened, using prompts and facial expressions including head nodding to encourage her, to verify points, as well as to follow up on leads and hunches. Points of special interest were jotted down some of which needed further probing in order to elicit the required information. The interview lasted forty minutes, after which I thanked the manager for her time and promised to keep her updated with the progress of the study.

The interview with the second manager followed a similar pattern. The manager voluntarily offered to hold the session at my venue as a form of compensation for the several times he had to reschedule the appointment.

3.7 Ethical Issues

To ensure conformity with ethical requirements, I sought and obtained approvals as stated in (3.5.1) before starting the field work.

My insider position accorded me ease of access, including support from work colleagues and access to data sources. The later comes with attendant problems particularly with reference to the ethics of conducting a research study with or on individuals with whom one has a relationship (Gair 2002). Sim and Wright (2000) observe that nearly every research that involves human beings gives rise to ethical issues. I therefore very carefully considered the various ethical implications that the study might have on the staff participants, the participating wards, the NHS Trust and Middlesex University. Reflexivity enabled me to continually monitor the impact of the study on these entities (Gray 2004, Savin-Baden 2004).

To enable an informed decision on whether or not to participate in the study, I provided participants with adequate written information (Appendix C) about the study as well as further information as required. It was explained that participation was voluntary, that everyone was free to withdraw at any point without explanation, and that refusal to participate would not affect other relationships such as the training relationship.

I guaranteed privacy, anonymity and confidentiality to participants and stakeholders by documenting the rights in the information sheet and using reflexivity to ensure compliance. Going in to restrain a violent individual could be extremely frightening, and staff may sometimes perform outside recommendations. Considering that it required a great deal of courage and trust of the interviewer to disclose truthfully what happened, I reciprocated by ensuring anonymity through 'coding'.

I worked flexibly around the ward routine. No pressure whatsoever was put on the participants or on the wards. When plans were altered for example the number on the focus group sessions due to staff shortage, I empathised with and reassured the managers on each occasion. The same was the case when appointments were cancelled. I continually reminded myself about Costley and Gibbs' (2006) argument that ethics in research is not just about securing a signed ethical approval form, but about maintaining an ethos of care for the research subjects throughout the process and ensuring that they do not suffer harm from the research activities and outcome. Although I held some preconceptions about the topic of investigation, I very intently listened to the participants' accounts and ensured that neither my body language nor my utterances portrayed bias. The participants were thus encouraged to speak uninhibitedly. This no doubt enhanced the reliability of the data.

3.8 Limitations of the data collection methods

Both of the data collection methods used for this study shared a major weakness which stemmed from their reliance on the study participants' ability to recall incidents retrospectively, in some cases years back. In reality, some of the facts may have faded away. This may have been the case when a participant appeared to have gone completely blank and could not remember any of the restraint incidents in which she had participated despite clear prompts from her colleagues. This raised doubts about the accuracy of the data. Observing and listening intently from my position which was outside of the interview circle so as not to inhibit honest responses, I wondered whether it was the effect of being in the session with her senior colleagues. The facilitator (3.3) who, judging from the participants' facial language during the introductions was clearly unknown to them, skilfully and encouragingly asked the participant to let him know when she remembered. Equally, some recalls appeared muddled. Again I observed that the other participants' contributions helped to complete and clarify them – an advantage of focus group interview.

Perhaps because physical intervention relies on team work, the dynamics during the focus group sessions came across as that of a family that had faced a common challenge and that needed to stick together. That, coupled with the fact that they had learnt the same model of training from my team probably explained the apparent similarity of the responses noticeable also in the semi-structured interview participants' responses. Even where there were divergent views in the focus group sessions, they were delivered gently rather than in a heated debate characteristic of focus group interactions.

The focus group interview session followed the pattern for the semi-structured interview in using the guide questions rather than just one question for discussion. I thought that this helped to touch on all the important points required to answer the research question (1.5).

The uninhibited contributions from the participants got me closely observing and listening for any signs of distortion of facts, and mindful of possible trainer-trainee influence. Non-anonymity of the interviewees was a disadvantage of both methods of data collection. This was overcome by coding the data in compliance with the rules of confidentiality (Polit and Becks 2008).

My insider position came with the major challenge of preconceptions and assumptions. I held some strong views about aspects of the topic under study. Robson (2002) explained that researcher bias is what the researcher brings to the situation in terms of assumptions and preconceptions, and that these were known to unwittingly distort the interpretation of qualitative data. In order to achieve a valid and untainted accounts of the participants' experiences, I tried to acknowledge my position in the study and reflexively ensured that my body language for example was in compliance with Gray's (2004) suggestion that the way to combat bias is to constantly question one's practice and to adopt a critical attitude towards the data interpretation.

3.9 Transcribing data

All the interviews were recorded using two digital recorders. They lasted forty five minutes on average. The quality of the recording was good. The back-up recording was reassuring and helpful. I carried out the transcription after each interview. Again, I continued to theorize, reflect upon and compare the emerging themes from the transcribed data with those jotted down during the interviews. A colleague who was very experienced in transcribing checked the

transcription and filled in most of the gaps. The ‘rich’, ‘full’ and ‘real’ data generated (Robson 2002) was as exciting as it was daunting.

3.10 Data Analysis

Data analysis defined as the ability to process information in a way that is meaningful and useful to users is not a ‘bolt-on’ feature that can wait until all the data has come in (Robson 2002). Rather, it needs to start at the data collection stage (Gray 2004). Adhering to this principle, I engaged in information processing, thinking through and identifying patterns the moment that the interviews started. I was continuously theorizing and trying to make sense of the data (Taylor and Bogdan 1998). I tried to keep track of the emerging themes by constantly reflecting on the materials.

3.10.1 The qualitative component of data

By directing the data collection tools to the objectives of the study (1.4), the data output was mostly qualitative.

Some authors are convinced that qualitative analysis is a personal process, and as such; there is no prescriptive method (Smith 2008, Moule and Goodman 2014). It is also “a labour-intensive activity that requires creativity, conceptual sensitivity and sheer hard work” (Polit and Beck 2008 p507). In line with the objectives of phenomenological approach chosen for this study, my goal was to gain knowledge and insight about the phenomenon. In other words, by adopting the bracketing approach (Holloway and Wheeler 2010) and reflecting on, scrutinizing and interpreting the actions/inactions during restraint scenarios as described by my study participants, I expected to learn whether they restrained in patient caring manner and whether such practice was effective with their patient groups in answer to my research question (1.5). This was in line with Boud, Keogh and Walker (2013 p.7) who opined that “*reflection is an active process of exploration and discovery which often leads to much unexpected outcomes*”.

3.10.2 The derivation of themes and categories

Authors on phenomenological research such as Colaizzi (1978) and Giorgi (1985) suggest that the entire description or transcript is read in order to get the sense of the whole. Reiterating, Polit and Beck emphasise that insight and themes cannot emerge from qualitative data until complete familiarization is achieved (Polit and Beck 2008). Adhering to this suggestion and following Moule and Goodman’s (2014) and Holloway and Wheeler’s (2010)

recommendations for analysing focus group data which I found similar, systematic and suitable for my size of data, I read the transcribed data several times to familiarize myself with the content. The activity enabled the identification of the initial themes. Some of the emerging themes corresponded with the ideas that came up during the interview and the transcription stages. Additional ideas were also identified. Coding was achieved by extracting the essence of ideas within paragraphs and sentences (Holloway and Wheeler 2010). This process was repeated with each focus group data set. The outcomes were compared and links were established across data from all the focus group transcripts. This process further reduced the data and produced some new displays to support ongoing conclusion drawing. The similarly treated semi-structured data sets were linked to the focus group set. The further data reduction produced even fewer themes. Closer scrutiny and more reading enabled the identification of six core themes.

The final search for and categorization of the meaning units (Moule and Goodman 2014) was carried out. They were all clustered in relation to the themes. An examination of the category clusters showed two distinct clusters from the second of the six core themes. These were presented as sub-themes (Appendix K, Figure 2). The numbering of the questions in each data set table to aid the identification of quotes from it was undertaken. Table 3 (Appendix H) is a sample. Appendix J gives the key to the codes. The categories identified in all the data sets were displayed for an 'at a glance' effect in Table 4 (Appendix I). The themes, sub themes and categories were used to present the findings in chapter four.

3.11 Conclusion

In line with the characteristics of qualitative studies, this investigation was not about the generalization of findings. Rather, it was a quest for deeper insight into the phenomenon (patient centred physical restraint). As such, the frequency of the categories contained in the themes that were found was not as important as their significance to the study (Holloway and Wheeler 2010). Essentially, the objective of the study was to find out whether the patient centred approach to physical restraint worked with mental health inpatient groups. The findings were therefore judged on their contributions to the objective of the study and not on their commonality. Every identified category was acknowledged and given attention irrespective of how many times it appeared in the data sets.

Chapter Four

FINDINGS

4.1 Introduction

This chapter traces the categories contained in the six key themes that were derived from the analysis of the data as explained in 3.10.2. A further scrutiny revealing two category clusters within theme two necessitated the creation of two sub-themes from theme two. The themes, sub-themes and their category clusters are displayed in figure 2 below. The category clusters listed in the left column were derived from the data collected from both the focus group interviews and the semi-structured interviews. Appendix H is a sample. The themes listed in the right column were each selected as representational of a cluster of categories or as in the case of theme 2, a combination of category clusters.

A detailed analysis of the themes is considered after figure 2. The themes are presented in a sequence that hopefully flows and makes an easy reading. It follows that the categories do not necessarily display in a corresponding order to the questions that produce them as shown in Appendix H. The reader can locate a quotation of interest on Appendix H using the question number attached to the quote. In addition, a given question in Appendix H may contain more than one code/category.

As previously mentioned in 3.8, guide questions similar to those used for the semi-structured interviews were used for the focus group interviews. Whilst this approach was effective in covering the points required in order to answer the research question ‘How effective and sustainable are patient centred manual restraint practices in mental health inpatient wards?’ it resulted in apparent similarity of responses from the groups. The reader will notice however that the responses to the ‘prompts’ break this apparent uniformity of answers, obviously because a prompt depends on what is said and what needs to be clarified.

Equally, the reader may notice that some voices are heard more than others. This is partly because while some people are succinct in their use of words, others elaborate. Additionally, the semi-structured interview participants, whose role was to instigate and monitor the restraint

procedure had apparently more to say than the individual member of the focus groups whose role was 'hands-on'. The quest as stated in 3.11 was for insight into the phenomenon. Other than prompting and encouraging every member of the groups to contribute, no attempt was made to make their contributions even. Every additional point from a participant was welcomed and valued. The choice of which excerpts to display from the transcribed data was determined by the need to elucidate and validate the findings in a way that the reader would find them convincing.

Comments from me happen where they are necessary to aid clarity. For the main part and to allow an easy flow of the reading, I have reserved my commentary for the discussion chapter. Additionally, I have used three dots to indicate that words had been left out that did not contribute to the understanding of what was being said.

4.2 THE THEMES

<u>Key to the quotes from the data sets:</u>	
Fg	Focus group
Ss	Semi-structured
q	question

4.2.1 THEME 1: PHYSICAL RESTRAINT OF A PATIENT IS FOR SAFETY

Each of the participants in both the focus groups and the semi-structured interviews was asked and each defined understanding of physical restraint of patients using their own words. This exercise was considered necessary to ensure that all were exploring the same phenomenon. In general, the participants had similar understanding of what physical restraint of patients was.

4.2.1.1 *Physical restraint is for maintaining safety*

The definitions one way or the other implied that staff physically restrained patients in order to maintain a safe ward environment. The focus group participants pointed out that they used it as a last resort option.

“I understand that aam this is a last resort nursing intervention that we do carry out to manage a violent patient when everything else fails...” (Peter Fg1q1).

“... It is a last resort option to de-escalate a situation and maintain a safe environment” (Nicky Fg3q1).

“Manual restraint is eem physically like removing a patient from a situation to safeguard either his or her safety or that of others...” (Zoe Fg4q1).

“Well, manual restraint, you could be talking to the patient and trying to come to terms in a way that the patient will be satisfied and you will be satisfied as well...” (Rose Fg2q1).

It is noteworthy that Rose’s (Fg2q1) definition seemed to imply non-physical engagement with the patient. She made this clear when she continued:

“... the wellbeing of the patient at the time, talking to the patient by communication for instance not using any force... Just having a kind of agreement sitting down and trying to solve problems ...” (Rose Fg2q1).

By Rose’s further explanation, the focus appeared to be on de-escalating the situation using skills other than hands-on.

4.2.1.2 *Physical contact is involved*

The semi-structured interview participants laid emphasis on the physical contact involved

“It means we as nurses physically hold a patient. So we are actually putting hands on them, to control a situation or to guide them away from a situation, so there is a physical hands-on touching of another person” (Moses Ss2q1).

“It means the staff have to use their training and therapeutic management of violence and aggression to physically actually intervene with a patient to prevent them harming themselves or others, or property” (Joy Ss1q1).

Moses and Joy were responsible for monitoring the physical restraint procedures in their respective wards. Their role was to observe everything particularly the holds and other contacts with the patient during the process in order to ensure that the restraint was conducted safely. No wonder their emphasis on the physical contact entailed in the process.

4.2.1.3 *Restraint can only be either therapeutic or punitive*

A semi-structured interview participant emphatically stated that restraint can only be either therapeutic or punitive maintaining that their job as nurses was to care for their patients and that if in the process they needed to use the restraint tool, they did so in the same spirit of care.

“From my experience that’s the only way it should be carried out. The alternative to that is that it is carried out in a punitive way which is not helpful to any one and certainly doesn’t build any kind of therapeutic relationship with your patient ... (Moses Ss2q2).

Reiterating, Peter from focus group one added;

“The view that we have is that what we are going to do is not something that is a punishment therefore I don’t want to be involved. No, it is a therapeutic intervention...” (Peter Fg1q12).

These responses seemed to indicate that these groups of mental health ward staff saw the physical restraint of their patients as a way of caring rather than as punishment.

4.2.2 **THEME 2: PATIENT CENTRED PRACTICES DURING RESTRAINT PROCESS**

Both the focus groups and the semi-structured interview participants shared the different practices which they adopted during restraint procedures that they believed helped them to achieve patient sensitive physical restraint. These readily fell under two sub-themes: issues relating directly to the patient and issues relating to the restraint procedure itself.

4.2.2.1. Sub-Theme 1. Issues relating to the patient:

4.2.2.1.1 *Knowing the patient*

Alice from focus group one believed that good knowledge of the patient can help when trying to de-escalate a situation.

“... It might not be actually in the notes because after a while you get to know some patients. And know their dislikes and likes. That helps a lot” (Alice Fg1q8).

4.2.2.1.2 *Awareness of cultural issues*

Carrying on, Alice said that knowing the patient’s background and sensitivity in handling cultural issues was also helpful. She shared an experience:

“I’ve witnessed a situation where the most senior member of staff on the ward tried to talk to a patient, a Moslem patient. He felt that you know, because he was Moslem, he didn’t need a woman telling him what to do... He wanted, he communicated better with males than with females because of his religion. So, knowing all those things as well about a patient does help” (Alice Fg1q7).

4.2.2.1.3 *The importance of building a rapport with the patient*

The participants talked about the importance of having a good therapeutic relationship with the patient. Rose from focus group two said:

“...sometimes I don’t know, may be the experience that I’ve had and the relationship that I’ve built with them over the years, they tend to listen to me more, to calm down” (Rose Fg2q3).

Reiterating, the semi-structured interview participants said:

“... And you know, if you’ve got a therapeutic relationship with your patient then you know you can go on to them the next day or day after and sit down and talk about what happened with them...” (Moses Ss2q7).

“She and I had good relationship before that so that she didn’t try to hurt me at all” (Joy Ss1q4).

4.2.2.1.4 *Seeking alternatives*

The participants said that they would try to negotiate alternative solutions with the patient.

“...So there are other interventions you could use without using physical...” (Evan Fg2q3).

“They made it clear to her that the behaviour was unacceptable and offered alternatives to her. She calmed down eventually...” (Florence Fg3q3).

“...you speak to the patient, explain the situation, offer her choices...” (Zoe Fg4q4).

“... I think if staffs recognize that themselves, then they are the ones who would use restraint less often. They are the ones who would look at the alternatives but know at the same time yes, there is a point where I have got to intervene...” (Moses Ss2q6).

The above responses seemed in line with the participants' earlier claim that physical restraint was a last resort option in their management of untoward incidents.

4.2.2.1.5 *Involving the patient*

A semi-structured interview participant explained that when possible, they tried to involve the patient in negotiating alternatives in an effort to avoid physical restraint.

“Eem in terms of restraint, where it is a planned one, for example, a patient refuses to take a depot medication, we have a lot more time to think about what we are going to do, how we can involve the patient...” (Moses Ss2q3).

Involving the patient in negotiating alternatives seems a powerful way of de-escalating the situation.

4.2.2.1.6 *Getting a colleague with whom the aggressive patient relates well*

The focus group participants said that they would normally get a colleague with whom the aggressive patient relates well to try and speak with and de-escalate the patient.

“So there's, you know, before you go on you know to the extent of the restraint, just exercising all options to see if there is somebody who could de-escalate them especially patients who have different relationship with other staff...” (EvanFg2q2).
“We talk to the patient and inform him/her of what we are doing. Explain why we are using 'control' and restraint... Involve staffs that are familiar with the patient...” (Florence Fg3q2).
“... but always, we try and get somebody with whom they get along to explain” (Peter Fg1q11).

This claim could have an implication with the use of restraint team members from other wards who do not know the patient and who the patient does not know.

4.2.2.1.7 *Trigger is removed*

If necessary, a team member is removed to calm the situation the participants said.

“...if the patient is actually very agitated with you know someone who's got their arm for example and is struggling with them, do I swop that person and get someone who's not the target for the patient's agitation and aggression? (Moses Ss2q4).
“In a recent restraint incident involving my primary patient, I took over from a restraint member about whom the patient was agitating.....” (Steve Fg3q3).

The primary nurse is arguably one member of staff who is likely to be familiar with his/her primary patient. It is noteworthy the role he played here.

4.2.2.2. Sub-Theme 2. Issues relating to the restraint procedure:

The participants explained some actions/inactions that they adopted in order to ensure that the restraint procedure itself was conducted as safely and therapeutically as possible.

4.2.2.2.1 *Non-threatening stance*

Peter from focus group one explained that they would adopt non-threatening stance when approaching the patient.

“Aam, we’ve always tried to adopt the non-threatening approach whenever we approach patients. You don’t want to come across as threatening. We always want to just keep your arms by the side not to come across as if you want to engage them in a fight of any sort” (Peter Fg1q5).

This effort by the team to display a non-threatening body language appears to be another significant way they tried to defuse the situation.

4.2.2.2.2 *Lead person*

When it was a planned restraint, the participants said that they would approach the patient in a team formation where one team member took the lead role.

“Aam, yes, sometimes when it is a planned restraint then you go with a team formation where you have somebody always taking the lead role and they’re talking to the patient...” (Alice Fg1q5).
“... one person leads during the process, ... checking the patient’s physical state...” (Florence Fg3q4).

Adding his voice, Andy from focus group four said:

“I approached the person actually; I was the one in charge. I spoke to the person in a very kind of calm manner...” (Andy Fg4q4).

Apparently, the participants understood the importance of just one person leading and engaging the patient in communication rather than every member of the team talking to the patient at the same time – a practice that might lead to confusion for the patient and probably further aggression.

4.2.2.2.3 *Tone of voice*

Alice said that they endeavoured to maintain a low tone of voice so that the patient didn’t feel threatened. At the same time, they would be trying to calm the situation.

“... what I found is if the patient is already agitated and they’re shouting and you shout it makes the situation worse...” (Alice Fg1q6).

4.2.2.2.4 *Clear command*

Peter from the same group, in apparent but gently delivered difference of opinion, emphasised how they used clear and concise command which he claimed helped to shorten the process so that the patient is restrained for the briefest length of time.

“But I’ve noticed that once the restraint starts and you are at that stage where you need somebody to be in charge and lead the full process so that the whole process is short and we limit the amount of time spent while the patient is under restraint, you tend to just kind of give commands ... Because what tends to happen is that if you don’t have that kind of clear command during that restraint procedure, you then find that the whole process takes aam forever...” (Peter Fg1q6).

4.2.2.2.5 *Appropriate and non-pain-compliant holds*

The focus group participants said that they tried to ensure that their holds were appropriate for the patient’s level of agitation and never intentionally caused pain to the patient:

“We use minimum force depending on the level of agitation. For example when leave was not granted to a patient, she became angry and wanted to throw and break objects. Staff used ‘figure 4’ holds and seated de-escalation and managed to calm down the patient” (Nicky Fg3q3).
“... most times we use level ones. I can’t remember [laugh], if we go into you know four. To me it is a good thing because the patients gain that trust in you...” (Evan Fg2q5).

Reiterating, a semi-structured interview participant said:

“So, someone is perhaps kind of distressed and may be banging their head on the wall, you would perhaps only need to hold their arms and remove them from the situation” (Joy Ss1q3)

The participants apparently considered that the ability to match the patient’s level of agitation with an appropriate hold would not only help in safely managing the situation physically but would also complement their de-escalation efforts.

4.2.2.2.6 *Gender issues*

The participants said that they tried to ensure same gender presence within the restraint team when restraining a patient.

“... Ye on a particular shift, not have just all males or not to have all females on one shift. Just kind of balance it out. Because if you want to restrain a female, you also want a female to be involved...” (Peter Fg1q13).

4.2.2.2.7 *Communicating with the patient during restraint procedure*

The importance of someone talking to the patient during the restraint process in order to calm down or de-escalate the situation was emphasised by the semi-structured interview participants:

“I suppose my main purpose there is to check ... that if it’s not myself, that someone else is you know speaking to the patient during the restraint” (Joy Ss1q4).

Similar practices were shared by the focus group participants:

“So I explained to the person the procedure. And when we went actually we told her it won’t be to hurt you in anyway. It’s only to help you. And I think the patient took it well” (Andy Fg4q4).

“We talk to the patient and inform him/her of what we are doing. Explain why we are using ‘control’ and restraint”. (Florence Fg3q2).

“... And I have a style of talking to them. I don’t care how bad the situation ... They listen and change their mind straight away...” (Rose Fg2q3).

Rose’s response seemed to explain why she defined physical restraint (4.2.1.1) as anything but physical to de-escalate the situation.

4.2.2.2.8 *Knowledge of team members’ strengths and weaknesses*

Some participants emphatically stated that knowing one’s team members’ strengths and weaknesses was paramount in achieving patient centred physical restraint

“It tends to work out well if it is colleagues on the same ward.... Even if it is not planned, but as long as it is staff from the same setting because we have that understanding...” (Peter Fg1q2).

4.2.2.2.9 *Co-ordinating the process*

The semi-structured interview participants went through some of the things they did whilst co-ordinating the process including:

“...if it is a long restraint, that people are being relieved... ..making sure that the environment is safe... .. that people are safe, that the patient is safe...” (Joy Ss1q4).

“...ensuring that patient’s airway and so forth is not obstructed... .. standing back and observing...” (Moses Ss2q4).

This non-exhaustive list of co-ordination activities underscores the importance of someone not physically engaged in the restraint process monitoring and ensuring that the process is conducted in a patient caring manner.

4.2.3 THEME 3: BARRIERS TO PATIENT CENTRED PRACTICES DURING RESTRAINT PROCESS

This theme was all about staff and their concerns regarding the patient centred model of physical restraint. They identified a number of things that could hinder patient care during such a restraint process. These included:

4.2.3.1 *Poor assessment of the situation*

Alice from focus group one said that assessing a situation wrongly and committing an inadequate team could hinder the process.

“What could go wrong is if you make the wrong decision to go in and restrain. Let’s say there are only two of you when you probably need three or four people...” (Alice Fg1q10).

4.2.3.2 *Injury during restraint procedure*

Peter, also from focus group one stated that even with an adequate preparation, if someone gets injured during the process, such could impact on the success of the restraint procedure.

“...you could end up with a member of staff injured or in the process of bringing the patient down because they are struggling themselves, they can end up getting hurt themselves...” (Peter Fg1r10).

4.2.3.3 *Shortage of staff*

Participants talked about the effect of staff shortage particularly when a restraint procedure needed to be carried out.

“... I’ll say staffing levels will make the interventions much easier. On this ward we are well staffed but on the other wards staffing levels tend to affect ...” (Peter Fg1q13).

“...Anyway the problem we have... if, sometimes staff call in sick. May be we don’t have a strong enough team for restraint. Getting a few bank people that are not really, haven’t gone for the ‘C&R’, it becomes a problem...” (Evan Fg2q7).

The discussions about staff shortage inadvertently lead to the discussion about emergency response team.

4.2.3.4 *Emergency response team*

Carrying on, Evan said:

“...You may call for help but you don’t know what’s going on in the other ward, whether there are regular there or not or there are Bank people... So you don’t know who is coming even if you do pull the alarm or call for help...” (Evan Fg2q7).

Sharing her concerns regarding the use of staff from other wards during restraint procedure, Florence from focus group 3 said:

“Getting restraint staff from other wards – such staff may use non-patient sensitive strategies”.
(Florence Fg3q6).

On further probing, Florence clarified:

“Such staff’s behaviour might include insensitivity and poor communication” (Florence Fg3q6).

Asked how she would deal with such, she answered:

“It depends on the situation – may be ask another staff to take over – may be address it during debriefing ...” (Florence Fg3q6).

The last response directed the discussion to the issue of debriefing following a restraint process.

4.2.4 THEME 4: DEBRIEFING AFTER PHYSICAL RESTRAINT INCIDENTS

The participants talked about the emotional responses that physical restraint could generate and how they dealt with such issues both during and after the restraint process.

4.2.4.1 Restraint and emotion

A semi-structured interview participant was very emphatic in stating that restraint should evoke an emotional response.

“Any restraint should always evoke an emotional response We are dealing with real people and the fact I’ve got to resort to either an emergency or a planned situation to putting hands on another human being, if that doesn’t concern me then I’m in the wrong job... ..being actually able to recognise ‘I’m angry’ and then being able then to walk away once the control is there...
(Moses Ss1q6).

Moses’ response seemed to explain why both semi-structured interview participants said that they would pull out an assaulted staff from the restraint team.

4.2.4.2 An assaulted team member is removed

The semi-structured interview participants said that they would usually relieve any member of the restraint team who had been assaulted by the patient being restrained - a practice they believed that helped to prevent someone restraining in anger:

“...if someone has been assaulted and may be they are in the restraint team and they are angry, you can tell by their interactions with the patient that you remove that person from the situation...” (Joy Ss1q4).

“Look and see if the member of staff who’s involved is somebody who’s actually been punched by the patient ... to really pull them out you know. Swop them over with someone else”
(Moses Ss2q4).

Sharing how he felt during a particular restraint process, Andy from focus group 4 said;

“When I saw the person stressed in that way, actually I was really concerned personally...
...When you think about it, it feels as actually it might have been inhumane in itself... ..later
on we get communication from him and he said actually I feel much better now. You see that
inhumane part of it actually it disappears...” (Andy Fg4q4).

4.2.4.3 *Participating in the restraint of a primary patient*

When asked how they felt about participating in the restraint of their primary patients, Peter from focus group one said:

“The view that we have is that what we are going to do is not something that is a punishment therefore I don’t want to be involved. No, it is a therapeutic intervention and therefore everyone agreed that at this point this patient needs it. And therefore just like giving an injection, primary nurse doesn’t say...” (Peter Fg1q12).

Steve from focus group 3 said that he felt quite comfortable after initially doubting the wisdom of participating in the restraint of his primary patient:

“Initially I kind of thought ‘hmm’ should I really? But then I did and I was quite comfortable with that and so was my patient” (Steve Fg3q9).

When asked whether their patients had complained about the psychological/emotional trauma as a result of restraint experiences; Zoe from focus group 4 responded very emphatically:

“That’s when the debriefing comes in. The experience is traumatic, yes. But once you debrief and reassure the patient then you know and then you try to engage them again. So, as I said before, you rebuild the therapeutic relationship” (Zoe Fg4q8).

Zoe’s response took the discussion straight on to debriefing after the physical restraint of a patient.

4.2.4.4 *The importance of debriefing*

All the participants acknowledged and emphasised the importance of debriefing even if brief due to lack of time. They debriefed themselves, the patients and necessary others they said.

“... It’s important afterwards to debrief them so that they know why they were being restrained. Explain to them why it got to the situation that they got to... because that explanation there might prevent it from happening again” (Evan Fg2q5).

Focus group 3 had more to say regarding debriefing

“It is important to check that everybody is fine and calm. Some staff don’t bother with debriefing. But then shortage of staff makes it difficult...” (Florence Fg3q8).

Florence’s acknowledgement that shortage of staff could impact on debriefing after a restraint incident highlighted yet another negative effect that staff shortage could have on the sustainability of the patient centred physical restraint in a mental health setting.

Continuing the discussion, Nicky from the same group answered affirmatively when asked whether they debriefed patients

“Always, when the situation has calmed down, staff sits with patient to examine the incident and to consider how it could have been prevented...” (Nicky Fg3q8).

The responses implied that there was an appropriate time for debriefing the patient.

4.2.4.5 *Right time for debriefing*

The semi-structured interview participants’ responses reiterated as well as emphasised the importance of debriefing the patient at the right time.

“... then once the patient calms down you get them ... I mean it is not always useful in the sense that sometimes it can actually escalate the situation again ...you have to be careful when you actually debrief. ...But perhaps the next day or even the day after, when you know you can talk to them about it...” (Joy Ss1q7).

“Aam so yes it can be done at the right time. And you know if you’ve got a therapeutic relationship with your patient then you know you can go on to them the next day or day after and sit down and talk about what happened with them... (Moses Ss2q7).

The responses implied that these participants viewed debriefing a patient after a restraint incident as an activity that required careful management and that should be carried out by someone with therapeutic relationship with the patient

4.2.5 THEME 5: ADVANTAGES AND DISADVANTAGES OF PATIENT CENTRED RESTRAINT PRACTICES

The participants shared what they considered as the advantages and the disadvantages of patient centred model of physical restraint.

4.2.5.1 Advantages

4.2.5.1.1 *Physical intervention is helpful*

Without necessarily using the terminology ‘patient centred physical restraint’ participants insisted that physical intervention as a management tool for aggressive/violent incidents was helpful

“I think it’s helpful because we use it as a last resort. Sometimes the patients get to a point where they themselves have lost control and by restraining, physically restraining them, you’re

actually giving them back that control. ... After a restraint, when you debrief a patient, they do tell you actually thank you may be I needed that. I got to a point where you know I was so angry ... (Alice Fg1q9).

The following advantages were identified by focus group 3 participants

4.2.5.1.2 *Risk minimization*

The group claimed that the patient centred approach to physical restraint reduces the risk of injuries to the patient during the process:

“...minimizes risks to patient and staff” (Nicky Fg3q5)

Adding his view, Steve said:

“...patient feels that staff care about him or her and so does not resort to violence” (Steve Fg3q5)

4.2.5.1.3 *Quick retrieval of relationship*

Meanwhile, Florence believed that the approach ensured the retrieval of the relationship with the patient.

“enables quick retrieval of the therapeutic relationship. ...safe manner to maintain relationship...” (Florence Fg3q5)

Rose from focus group 2 who perceived patient centred restraint as reliant on de-escalation skills had this to say:

4.2.5.1.4 *It calms the ward*

“It calms the ward. Sometimes it makes the patient feel they are worthy; they are wanted in the environment. They feel free in their approach. They have no fear...” (Rose Fg2q5).

4.2.5.1.5 *Patient is grateful in the end*

Adding his voice, Andy from focus group four shared an experience:

“... It is a cry for help. And you see without the ‘control and restraint’, I don’t think there will be any other alternative of giving that help ... I remember one of the patients who was actually chaotic all night because the voices were so intense... We offered other kinds of therapeutic interventions and they all failed ... We called the team and we restrained that person. Gave her medication and actually we saw a big change within two hours after the restraint and even the person herself rather than now actually regretting it, said ‘thank you very much... (Andy Fg4q4).

4.2.5.1.6 *Disseminating patient centred physical restraint approach*

When asked whether they would recommend patient centred physical restraint approach to similar care settings, Moses responded almost irritably:

“I don’t think we should have to recommend it to anyone. I think it should be the philosophy no matter where you work, you know, that we are there to look after the patient who because of their illness is behaving in this aggressive way or because they don’t believe they are ill, they don’t agree with having medication for example so you need to intervene. But you need to intervene in a way that is actually explaining to them the why...” (Moses Ss2q9)

4.2.5.2 *Disadvantages*

On the disadvantages of patient centred physical restraint, the following points were made:

4.2.5.2.1 *Differences of opinion*

A participant said that differences of opinion among staff could hinder team work. Making her point, Joy said;

“...someone might think well it wasn’t necessary to walk that person with their arms held. But you know, I think that’s quite subjective and you can’t actually know which way to have gone really”. (Joy Ss1q6).

4.2.5.2.2 *Delayed intervention*

Moses raised the view that patient centred model of physical restraint could lead to a situation where physical intervention is delayed until something very serious happens.

“But at the end of the day if I’ve got a patient who is really unwell and suffering as a result of their illness, then standing by and not doing anything is worse...” (Moses Ss2q5).

4.2.5.2.3 *Reluctance to take control*

Continuing, Moses said that one of the negatives of the model was that people tended to hesitate in taking control of a situation.

“... I suppose one of the risks is that people don’t take control of a situation, either because they don’t want to upset the patient ...” (Moses Ss2q5)

Reiterating Peter said;

“... when everything else has failed, you can’t just stand and watch while somebody is getting injured...” (Peter Fg1q15).

4.2.6 THEME 6: TRAINING

One of the objectives of the study was to find out what suggestions the study participants would make that could help to improve the model and make it sustainable in the setting. Views were therefore sought from the participants on how the training provided for them by my team could further be developed. The participants expressed satisfaction with the existing package.

“As far as the update goes it covers everything that we could expect on the ward. Yes, I find it quite adequate you know and good refreshing to be able to use obviously if we need to use it as a last resort” (Evan Fg2q7).

“I think over all I’m happy with the training...” (Joy Ss1q9).

Whilst no complaints were raised regarding the training, observations and suggestions for improvement were nevertheless made including:

4.2.6.1 *Intensive role-play*

In Moses opinion, more intensive role-play especially on how to deal emotionally with abuse from the patient during a physical restraint process would be helpful to the staff in the ward setting.

“My only concern with the training and it’s not the way the techniques are taught. I don’t have an issue with that. I think that you know, from coming here numerous times that you know the techniques are taught well. I know there was experiment a couple of years ago whether it would be one day refresher rather than two. I certainly would advocate for the two days refresher. I feel sometimes the one day can be quite rushed in terms of what you are trying to do. ... So to me doing a two day course where you can do more role play, more practice...” (Moses Ss2q8).

4.2.6.2 *Team training*

Peter thought that having teams from the same ward attend their annual update at the same time would make their practice more effective.

“I think it comes down to staffing levels. If let’s say we have enough cover on the wards, I mean going for updates as a team from this ward and not mix with other ward members would help because you then tend to perfect those techniques as a team (Peter Fg1q14).

4.2.6.3 *Non- involvement of allied professionals*

There was an expression of annoyance from Moses about the non-involvement of allied professionals in patient restraint.

“... the attitude thing ‘well that’s a nursing thing to restrain a patient’. Well no it’s not and I’ve always been miffed that Doctors, Occupational Therapists, Psychologists don’t actually get involved in that aspect of our job ...” (Moses Ss2q5).

Moses' was the last of the interviews. There was no opportunity to seek the opinions of the other participants regarding training up other professionals in the setting so that they could all participate when there was need to restrain a patient.

4.2.7 Conclusion

The findings demonstrate how uninhibitedly and indeed genuinely the participants interacted in the study. Bearing in mind the differences in their patient groups (3.5.3), I found their accounts remarkable, in that their philosophies and approach to practice with regard to physical restraint of their patients were strikingly similar.

The above key themes will be further discussed in chapter five.

Chapter five

DISCUSSION

5.1 Introduction

I stated in chapter four that this chapter would engage in more detailed comments regarding the findings from the study. Where necessary, the reviewed literature will be referenced and excerpts from the transcribed data used to validate and vindicate claims or to clarify conflicting views.

The themes used in the discussion below are the same as displayed in figure 2 (4.1). The process detailing how they were derived was explained in ‘the derivation of the themes and categories’ (3.10.2). They were presented in descending order in chapter four and will be explored in the same order in this chapter.

5.2 Key themes emerging from the data:

Physical restraint of a patient is for safety.

Patient centred practices during restraint process

Barriers to patient centred practices during restraint process

Debriefing after physical restraint incidents

Advantages and disadvantages of patient centred restraint practices

Training

5.2.1 Theme 1: *Physical restraint of a patient is for safety*

The study participants’ use of the rather popular phrase in the subject area ‘last resort option’ is interesting. I think that there is need for caution here as individuals’ or indeed ward cultural interpretations of the concept may differ. Where as to some it might mean that they have tried a range of alternatives and negotiations pointing to what critics may term the ‘*softly, softly approach*’ (Moses Ss2q5), to others it might mean very limited alternatives and no negotiation, an indication of power imbalance (Gilburt et al. 2008). However, judging by the accounts, there appeared to be a reasonable balance in the participants’ practice. They explained that restraint was used to maintain safety. This is in line with Duxbury (2002) and Duxbury and

Whittington (2005) who perceive restraint as inevitable and needed in order to maintain safety. A similar notion was shared by others such as: Irwin (2006), Stewart et al. (2009), Kontio et al. (2010) and reiterated by participants in Guilburt et al. (2008) who claimed that they experienced a sense of safety when staff were able to intervene physically in order to control an incident that might have affected others.

The focus group participants repeatedly talked about ‘de-escalating the situation’. This implies that it is not just about the physical holds, but also other patient-sensitive actions necessary to calm the situation. One group leaned so heavily on de-escalation that a participant in the group defined physical restraint as anything but physical to calm the situation “*talking to the patient by communication for instance not using any force ...*” (Rose Fg2q1). Listening to this participant narrate highly charged ward incidents brought under control without laying a hand on the patient brought to mind Irwin’s (2006) finding that the efficacy of de-escalation approaches relies on developed communication and personal skills. However, whilst this exemplifies patient centred care, one is concerned as was a participant in this study that it may also be a weakness of the approach if the staffs delay physical intervention until it is too late. “*... when everything else has failed, you can’t just stand and watch while somebody is getting injured...*” (Peter Fg1q15).

The participants of the semi-structured interview laid emphasis on the physical contact involved in manual restraint. Interestingly, even though trained in restraint skills, these individuals did not usually participate in the hands-on restraint of patients. Their emphasis on the physical contact lends weight to the general concern regarding physical restraint – a charged situation in which the outcome as regards injuries physical and/or emotional is unpredictable.

5.2.2 Theme 2: Patient centred practices during restraint process

Participants in this study perceived their patients’ aggressive and violent behaviours as ways of crying out. “*It is a cry for help*” (Andy Fg4q4). This patient-sensitive concern appeared to influence their general handling of scenarios requiring physical restraint in line with Marangos-Frost and Wells (2000) and Needham et al. (2004), who observed that nurses’ attitude towards aggressive behaviours would influence their choice and manner of intervention. The participants were emphatic about the quality of their physical restraint practice stating that

restraint can only be either therapeutic or punitive and maintaining that their job as nurses was to care for their patients. If in the process they needed to use the restraint tool, they did so in the same spirit of care they said. Their patient-sensitive practices when managing untoward incidents including continuous communication are in line with findings such as: Bonner et al. (2002), Duxbury and Whittington (2005) and Sturrock (2010). Their readiness to negotiate and to use other patient centred strategies is supported by the findings of Irwin (2006) and Larue et al. (2009).

I found the similarity in the accounts of physical restraint practices of these wards rather striking. One would be forgiven for assuming that their patient groups were the same. The account of heavy reliance on de-escalation skills was surprisingly from the all-male patient Psychiatric Intensive Care Unit - a clear example of practice hinged on experience, therapeutic relationship and trust from the patient (Irwin 2006, Bowers et al. 2007).

The identification of knowledge of one's team members or restraining with colleagues in the same ward as important for the success of patient-sensitive restraint was another interesting revelation. In my view, this certainly has its strengths, in particular, the members' knowledge of each other's capabilities. But, it might also come with some weaknesses such as reinforcing negative ward culture and impeding development (Kontio et al. 2010, Patterson et al. 2012).

A participant said that knowledge of the patient – *“his/her likes and dislikes”* (Alice Fg1q8) was very useful in de-escalating situations, a point highlighted by Kontio et al (2010), Irwin (2006) and Bonner et al. (2002). Sharing an experience to buttress the claim Alice continued: *“I’ve witnessed a situation where the most senior member of staff on the ward tried to talk to a patient, a Moslem patient. He felt that you know, because he was Moslem, he didn’t need a woman telling him what to do... He communicated better with males than with females because of his religion.”* (Alice Fg1q7). Ethnicity, cultural awareness and sensitivity in mental health services were very strongly flagged up in the panel recommendations following the enquiry into the death of David [Rocky] Bennett (Blofeld 2003). Echoing, NICE (2015) stressed the importance of these care elements in its guideline on the management of violence and aggression in psychiatric settings. Awareness of gender issues especially when carrying out searching and when intervening physically in violent and aggressive situations was emphasised in the same guideline (NICE 2015). Studies including Obi-Udeaja (2009) found that lack of gender awareness during physical intervention could cause profound psychological trauma to

the patient and adversely affect the therapeutic relationships with patients. It was reassuring that the participants in this study were aware of the importance of these patient centred practices during physical restraint as evidenced in the following response “... *Ye on a particular shift, not have just all males or not to have all females on one shift. Just kind of balance it out. Because if you want to restrain a female, you also want a female to be involved...*” (Peter Fg1q13).

One of the participants’ de-escalating options was to get a staff member with whom the patient relates well to talk to the patient (Evan Fg2q3). On the same note, some participants raised concern about restraining with staffs from other ward areas saying that such individuals might restrain insensitively (Florence Fg3q6, Winship 2006). This raises a question about the use of an emergency restraint team who might not know or have therapeutic relationship with the patient they are restraining.

By offering alternatives to the patient (Evan Fg2q3), participants demonstrated non-over-reliance on physical restraint justifying their claim about ‘last resort’ philosophy.

Both participants in the semi-structured interview had said that while coordinating a restraint process they would quickly replace a member of the restraint team who has been assaulted by the patient or is the source of the patient’s anger. Such intervention they said might help to de-escalate the incident and to prevent a potential punitive restraint.

5.2.3 Theme 3: *Barriers to patient centred practices during restraint process*

Shortage of staff was identified as a barrier to patient centred physical restraint. One of the study wards however said that they were usually adequately staffed; the other said that they would call for the emergency restraint team, the problem regarding which was discussed in theme two.

Assessing wrongly and committing an inadequate team to restraint process was cited as another barrier to patient centred restraint. According to the study participants, they usually would try other things before engaging in physical restraint such as offering the patient some alternatives, getting someone who gets on well with the patient to try and de-escalate the situation. This indicates a ward culture that is not overly reliant on physical restraint. Such ward is unlikely to

commit hurriedly and unprepared to a restraint process unless perhaps in an emergency situation.

The barriers identified by participants are management rather than training problems. One hopes that highlighting them in this study would draw the attention necessary for solution seeking.

5.2.4 Theme 4: *Debriefing after physical restraint incidents*

Participation in the manual restraint of patients can affect staff physically and emotionally (Moran et al 2009, Hollins and Paterson 2009) as it does the patients (Gilburt et al 2008, Winship 2010). It is acknowledged that post incident review including debriefing is a very essential part of the restraint cycle that enables a reflective review of the problem-resolution process (Larue et al. 2009). Participants in the study acknowledged that physical restraint was a traumatic experience for all involved. They said that they usually debriefed themselves but sometimes very briefly because of the need to get back to their respective engagements. Irwin (2006) had found that debriefing after a restraint procedure was not a regular practice. This admission by the participants of lack of time for proper staff debriefing was concerning. Such lapse in practice requires urgent attention if the concern regarding in particular the emotional impact of physical restraint is to be addressed. Going by the findings in some of the reviewed literature, individual differences might mean that while some people can cope with these traumatic experiences, others might struggle – the conflicted nurse (Marangos-frost and Wells 2000, Bigwood and Crowe 2008).

The participants also claimed that they debriefed the patient. According to Zoe, debriefing the patient enabled the staff to regain the therapeutic relationship with the patient. *“The experience is traumatic, yes. But once you debrief and reassure the patient then... you rebuild the therapeutic relationship”* (Zoe Fg4q8). This practice substantiates their claim of patient centred restraint practices. The participants consistently laid emphasis on the timing of the debriefing of the patient. According to them, debriefing a patient before s/he was calm enough to reflect on the issues could escalate the situation. *“... You have to be careful when you actually debrief... .. perhaps the next day or even the day after, when you know you can talk to them about it...”* (Joy Ss1q7).”

5.2.5 Theme 5: *Advantages and disadvantages of patient centred restraint practices*

While debate continues to rage about manual restraint – curtail it, prohibit certain elements of it and so on, staff on the shop floor, mental health in particular know that there are times when nothing else works. This argument is substantiated by authors such as (Winship 2006, Paterson 2007, Raija et al. 2010, Hollins and Stubbs 2011, DH 2014). Participants in this study claimed that when the patient had completely lost control, physical restraint enabled them to gain control of the situation and give it back to the patient when s/he was ready. Many a times the patient actually went back to thank them for the intervention the participants said. This claim was another indication that physical restraint as practised by these staff was patient sensitive. I thought that there was a discrepancy when many of the participants stated that patient centred physical restraint ensured a therapeutic relationship with the patient whilst a particular focus group insisted that any restraint, patient centred or not broke the relationship with the patient. The apparent discrepancy was resolved when the group in question added that proper debriefing of the patient helped them to rebuild the relationship. As I understood it, these two groups were actually saying the same thing. But, while the first considered the completed cycle that included the post incident activities (debriefing and review), the second group appeared to have considered the stages (the hands-on stage and the post incident stage) separately.

According to Nicky (Fg3q5), patient-sensitive physical restraint “*minimizes the risk of injuries to the patient*”. “*It makes the patient feel that the staffs care*” (Steve Fg3q5). These were very powerful claims and important advantages that might enhance recovery. And, quick recovery could translate into savings on resources.

The identification of delay in intervening and reluctance to take control as a disadvantage of patient centred physical restraint was concerning. The model of training provided to these staff boasts a hierarchy of holds. By intervening early, the staff can use a low level hold for example to guide a patient away from a trigger - a caring restraint as described by Winship (2006). Whilst intervening too quickly might mean over reliance on the tool which is certainly not advocated, leaving it late might mean using higher level or even pain compliant holds because the situation may have escalated.

5.2.6 Theme 6: *Training*

All the participants in this study acknowledged the importance of adequate training on the management of anger, aggression and violence from patients. Referring to unplanned intervention, participants said that knowing that one was restraining with colleagues who were trained, regularly updated and who knew what they were doing was reassuring (Alice & Peter Fg1q2).

Paterson et al. (2013) identified inadequate or inappropriate training among other issues as very potent in creating an environment for corrupted cultures. Larue et al. (2009) reiterating emphasised the need for adequate and comprehensive training that would enhance staff confidence in dealing with challenging situations. Abiding, both participants of the semi-structured interview affirmed that they ensured that all their staff were trained and regularly updated. “... everyone is updated. Eem ‘C&R’ and CPR are two areas that I try to make sure that everyone is trained because they are kind of emergency situations” (Joy Ss1q9).

The suggestion to arrange training update separately for the respective wards was given immediate consideration by my team. As acknowledged by the participants, this is hindered by the ward’s inability to release enough staff to make the suggestion viable. The training team tries to meet this suggestion by arranging for course members from the same unit to practise together when possible during training. Also, more role play is built into the training as suggested by the study participants.

Participants expressed displeasure that allied professionals shied away from physical restraint of patients. Ryan and Bowers (2006) wonder why restraint skills are not made mandatory for these professionals when restraint of patients is deemed inevitable especially in the mental health settings. I can understand the reluctance to be involved in the restraint process during the era of the pain compliant models when restraint was tantamount to punishment. I would however hope that the patient centred model of physical restraint which puts the patient’s interest in the forefront and specifies that the process itself must be patient-sensitive would bring about a change. Similar thought goes for primary staff nurses participating in the restraint of their primary patients. One hopes that the response from a study participant who confirmed that he and his primary patient felt comfortable after the restraint process helps in addressing this old concern. Indeed, a study participant in Steckley (2008) had said that he had only ever

been restrained by his key worker and that that made him feel better in his relationship with his key worker.

5.3 Reflection on the research process

None of the papers reviewed had similar objectives to the one for this study. It is therefore proposed that this work has explored a relatively unique aspect of investigation within mental health nursing.

The triangulation of research venue (two differently located mental health hospital wards) as used for this study could be useful for transferability of findings. However, this study is not about generalisation. Rather, it is about gaining further insight on the phenomenon in order to improve my team's training provision and to add to the body of knowledge.

The interactive strategy adopted for the study came with strengths and limitations including that conducting the fieldwork within the ward settings brought home more realistically the phenomenon in question. The direct interaction with the ward practitioners entailed hearing about restraint scenarios from the very people who carried it out or monitored the process. The face to face interaction with them enabled probing for deeper understanding (Kumar 2005, Pope and May 2006). This face to face setting however, compromised confidentiality (Parahoo 2006) and created room for bias (Robson 2002). These potential limitations were reflexively and effectively managed.

The collaborative approach with the study participants appeared to have generated in the participating wards a feeling of ownership of the project. They appeared excited and willing to contribute towards its success. Staff shortages and work pressure necessitating cancellation of appointments and the restructuring of and reduction in the numbers for the focus group were unhelpful limitations.

Both data collection methods used for the study shared a major weakness which stemmed from their reliance on the study participants' ability to recall incidents retrospectively. Some of the recall might not have been entirely accurate thus impacting on the reliability of data.

Whilst the focus group enabled a quick generation of data as well as support from peers, it might have threatened individuals' confidence. I had wondered whether such was the case when a participant in a group with more experienced colleagues appeared unable to recall any restraint incident she had participated in. This lapse was sensitively managed by the facilitator.

Whilst the small size meant no hiding in the crowd for the focus group participants; I thought that it almost reduced the focus group to 1:1 type interview thereby robbing it of some of its characteristics such as debating and disagreeing on issues that could enhance the reliability of data.

I had been anxious that the participants might be selective with their information because of the trainer-trainee relationship. On the contrary they spoke uninhibitedly, all of which was tape recorded in addition to the notes taken by my colleagues and I. The rechecking, validating and coding of the transcribed data by another colleague acted as checks and balances all of which actions helped to achieve rigour and to enhance the reliability of the data. The mitigating presence of the very experienced facilitator, the collaborative style of the investigation, in addition to the years of cordial relationship between the participants and me must have helped as well.

Conducting this investigation as a worker researcher under tight economic conditions meant constant interruption and often long suspension of the study due to shortage of staff in my team. Such breaks affected the momentum as well as the flow of thoughts and ideas. I was concerned that the situation might compromise the quality of the work. On the other hand, the study would not have happened but for the worker researcher status.

5.4 Conclusion

This chapter has critically considered the findings drawing on the reviewed literature and data analysis and supporting with excerpts from the participants' responses. A reflection on the field work and the findings brings to light the conscientious effort by these practitioners to adhere to the philosophy of patient centred physical restraint as promoted through the training provided to them.

In the next chapter, an overall conclusion on the study will be drawn and recommendations made.

Chapter Six

CONCLUSIONS

6.1 Introduction

In answer to the research question; ‘how effective and sustainable are patient centred manual restraint practices in mental health inpatient wards’, the findings from this study indicate that participants perceived their patients’ aggressive and violent behaviours as ways of crying out, ‘*a cry for help*’ (Andy Fg4q4). This patient-sensitive concern appeared to influence their general handling of scenarios requiring physical intervention. Their ready use of practices such as: communicating and negotiating with the patient to find alternatives, non-threatening stance when approaching the patient, non-pain compliant holds, debriefing the patient after a restraint incident lent weight to their claim to patient centred restraint practices during restraint procedure. The participants stated that their job as nurses was to care for their patients and that if in the process they needed to use the restraint tool, they did so in the same spirit of care. This indicated that their use of patient centred model of restraint was a sustained practice. Although from different ward areas, both groups of participants expressed satisfaction with the approach. They agreed that it minimized the risk of injuries to the patient, and that it enabled a quick retrieval of the therapeutic relationship with the patient. There was an apparent difference of opinion when one of the four focus groups insisted that any model of physical restraint inevitably destroyed the therapeutic relationship with ones’ patient. That however was clarified when they added that debriefing and re-engaging with the patient after the incident helped to rebuild the relationship. And, these post restraint activities are very much part of a patient centred physical restraint procedure. In other words, until they happen, the process is not complete. These findings confirm that patient centred approach to physical restraint works effectively with these patient groups.

The barriers to the approach as identified by the study participants, example, shortage of staff, appeared to be mostly management problems. It is hoped that highlighting such issues in the study would attract the attention and necessary questions directed towards their solutions.

Meanwhile, the suggestions for improving training such as more role play were carefully considered by my team colleagues and actions taken to implement them with immediate effect.

I propose that the recommendations below are based on the findings from this research and provide a further means of responding to answer the research question.

6.2 Recommendations

Some participants expressed concern regarding the use of 'emergency restraint team' where restraint staff members came from other wards. In their experience, such staffs were sometimes insensitive in their communication with the patient and in their restraint practices (Florence Fg3q6). Meanwhile, one of the findings was that knowledge of and therapeutic relationship with the patient could be helpful in de-escalating an incident and in achieving a patient centred physical restraint. Restraint team members from other wards are unlikely to know or have therapeutic relationship with the patient they are restraining. The use of emergency restraint team might be cost effective from a management perspective. However, this study has shown that there are concerns about it.

1. I therefore recommend that every member of staff is trained in both the theoretical and the practical aspects of physical restraint to ensure the availability of trained staff when needed. Alternatively, the trust can work on developing a more humanistic rapid response strategy.

Participants said that they were 'miffed' by the non-involvement of allied professionals in patient restraint. The patient centred model of physical restraint is therapeutic and non-punitive. Perhaps the model can convince these allied professionals that restraining a patient in his moment of crisis to save him from committing a crime, or holding and guiding a patient away from a danger (Winship 2006) is very much part of the caring activities.

2. This study would recommend that the allied professionals are made aware of the patient caring attributes of the patient centred model of physical restraint and educated on the necessity for them to have the training. No doubt this would mean a big shift in mind set, but it is a battle that the trust should be prepared to win.

As found in this study, one primary nurse's therapeutic relationship with his patient was if anything enhanced after participating in his primary patient's restraint. The primary nurse is most likely to have knowledge of his/her primary patient's likes and dislikes and to have a therapeutic relationship with the patient all of which is helpful in achieving patient centred physical restraint.

3. This study would therefore recommend that trusts adopt a policy that requires a primary nurse whenever possible to be around either to participate physically or to monitor and support the patient and the team during a restraint process.

The participants in this study acknowledged that restraint could be a traumatic experience for everybody involved including: the patient, the staff and the witnesses. They also said that debriefing helped to restore the relationship between the patient and the staff (Zoe Fg4q8).

4. I would recommend that:
 - a. Resources be directed towards finding out more about debriefing after restraint incidents
 - b. Trusts ensure the implementation of the practice of debriefing the people involved in physical restraint

In view of the difficulty in obtaining a reasonable number of participants for the focus group sessions in this study,

- c. I would recommend that until the staffing problem is resolved in the wards; similar studies may wish to discuss the likely resource implications and strategy for data collection so that the ward can actually release the number of study participants who wish to take part. Alternatively, other methods such as semi-structured interviews or questionnaires may be more appropriate.

6.3 Contribution to practice

Patient centred physical restraint has been developed as a ‘best practice’ model. It is intended to reassure patients that the staffs care about their wellbeing even when they (patients) are losing control. As claimed by the study participants, it enables a quick retrieval of the therapeutic relationship with the patient. Thus, indirectly it could promote recovery and ultimately savings on resources. As the model most likely to be perceived positively by the patient, the outcome is unlikely to pose an emotional burden either for staff, patients or for witnesses. Restraint team members, collectively and severally as well as the Trusts can, with clear conscience, face any panel of enquiry on matters of restraint outcomes. This is supported by Lord Carlile’s observation that “*if all do their duty, they need not fear harm*” (The Lord Carlile of Berriew QC 2004, Title page).

6.4 Dissemination

At the successful completion of this study and with support from my senior colleagues, I will take the campaign to a wider Trust level even as my team continues to use the study outcome to inform training. With the consent and cooperation of the study participants, the study will be published and presented in conferences.

Finally, it is my hope that this work makes a valuable contribution to future efforts in finding an acceptable method of restraining the mentally unwell especially in their moments of crises.

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Appendix A1

The Direction for Data Collection

This enquiry should be focused on the participants' experience of restraining patients in a caring manner and the meaning it has for the individuals. The questions and the prompts should be aimed at the staffs' experience of the lifeworld/patient centred restraint practices in their ward and their views regarding the phenomenon.

Interview Guide Questions

- Use to set the scene & to relax participants*
- What do you understand by manual restraint of patients?
 - How do you think this can be done in a therapeutic or patient caring manner?
 - How applicable in mental health settings is patient caring practices during manual restraint?
 - Do you use the approach with your patients? If you do, could you give some examples of how you have used it? *Prompts re participants reflection on roles) during the restraint process or the incident.*
 - What, in your view, are the advantages of such practices?
 - What problems if any did you encounter in using the approach?
 - Have you ever experienced emotional discomfort as a result of participation in a restraint process?
 - Can you describe the experience, that is, your thoughts and feelings?
 - Could you have done anything differently in terms of patient's care during the process? If so, please explain.
 - If patient centred restraint is the way forward, what suggestions do you have to make the procedure sustainable in mental health settings?

Appendix A2

Guide Questions for the semi-structured interviews of the ward key staff e.g. shift leaders

- What does the term physical/manual restraint of a patient mean to you?
- From your experience, can the process be carried out in a therapeutic or patient caring manner? Prompt – can you substantiate? *on: communication holds, cave, mgt actions? (prompts)*
- Can you please tell me about manual restraint of a patient which you've had to instigate.
- Did you coordinate the process and if so can you share your experience of it?
- What does it feel like observing rather than participating in the procedure?
- From your view point, how practicable were patient caring/sensitive practices during the procedure?
- * • Based on your experiences, what are the advantages of such practices? *pt. caring, restraint, practices*
- What problems have you encountered in the use of patient caring approach?
- Have you ever experienced emotional discomfort as a result of instigating or participating in a restraint of a patient?
- Can you describe the experience including your thoughts and feelings?
- What if anything could you have done differently in the situation?
- If patient centred restraint is the way forward, what suggestions do you have that would make the practice sustainable in mental health settings?

Appendix B

Jane Obi-Udejaja

From: [REDACTED]
Sent: 26 July 2012 09:09
To: Jane Obi-Udejaja; [REDACTED]
Cc: [REDACTED]; [REDACTED]
Subject: RE: Evaluation of training&practice

No problem Jane, happy to help.

Bw

[REDACTED]

-----Original Message-----

From: Jane Obi-Udejaja [mailto:J.Obi-Udejaja@mdx.ac.uk]
Sent: 24 July 2012 19:43
To: [REDACTED]; [REDACTED]; [REDACTED]
Cc: [REDACTED]; [REDACTED]
Subject: Evaluation of training&practice

Dear [REDACTED] and [REDACTED],

Thank you very much for your time today which enabled a further discussion about the planned collaborative work with your staff to evaluate their use of patient centred restraint strategies.

As I mentioned, Prof [REDACTED] will facilitate the focus groups. My colleagues [REDACTED] and [REDACTED] and I will like to sit in and take notes. I will find out [REDACTED]'s availability when he returns from annual leave on Thursday and let you know.

I feel confident that when completed, this will be an interesting and unique piece of work which we will all be proud to publish. Thanks again for agreeing to facilitate it.

Kind regards

Jane

PS

The attached is for you as discussed [REDACTED]. [REDACTED] will provide you with any further info .hat you require. Thanks for agreeing to facilitate the session on seclusion.

Bw

J

Appendix B (cont'd)

Jane Obi-Udejaja

To: [REDACTED]
Cc: [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]
Subject: Interview date

Hi [REDACTED],

Just to confirm that Prof [REDACTED] who will facilitate the focus group interview said he will be available for the session from the 1st of August to the 24th excluding the 13th.

Also [REDACTED] ward has reserved 2pm on the 6th of August for their interview.

Do have a very restful break.

Thanks and regards

Jane

:S.

[REDACTED], [REDACTED] and [REDACTED],

Above pls for your info.

[REDACTED] the manager for [REDACTED] ward in Highgate, our 2nd staff study collaborators informed me that he was going away on break and will arrange for the interview when he gets back on the 13th of August.

[REDACTED], the manager for [REDACTED] ward our 1st staff study collaborators was anxious in case there occurs an emergency in the ward on the day that may hinder the plan. I reassured her that the exercise would only proceed at their convenience. In other words she can ask for rescheduling within the time range that [REDACTED] has given. I hope you do not mind [REDACTED].

Best wishes

Jane



**Middlesex
University**

Department of Mental Health, Social
Work: & Inter-Professional Learning
Middlesex University
2nd Floor, Clerkenwell Building
2-10 Highgate Hill
London N1

Camden and Islington

NHS Foundation Trust

1. Study Title:

The use of patient centred manual restraint practices in mental health wards – a training needs analysis

Invitation:

You are being invited to take part in a training needs analysis. Before you decide, it is important for you to understand why this is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Contact me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

2. What is the purpose of the project?

The Middlesex University Therapeutic Management of Violence and Aggression (TMVA) team provides physical intervention training for Camden & Islington (C&I) NHS Trust.

This project aims to work collaboratively with C&I mental health ward staff who have undergone the Middlesex University TMVA model of manual restraint in order to explore their use of patient caring manual restraint practices within their wards. The project forms part of training improvement and development being carried out by the team. The overall aim is to work in partnership with the ward staff whilst exploring their perspectives on their practice of patient sensitive manual restraint. Findings will be used to inform training in order to improve practice.

3. Why have I been chosen?

We are recruiting volunteers from two mental health inpatient wards based in different hospital locations in Camden and Islington. All staff on these two wards are being invited to take part in the study. The next step is for you to read this information and to decide whether or not you would like to take part in the project.

4. Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form a copy of which will also be given to you to keep. If you decide to take part you are still free to withdraw at any time and you do not have to give a reason. A decision not to take part or a decision to withdraw will not affect your work in any way – or the training or education you receive at the University.

5. What will happen to me if I take part?

You will be invited to take part in an interview about your use of patient caring manual restraint practices. You will be asked about your experiences/perspectives and to make suggestions in your own words. To help to avoid unnecessary interruptions and to make sure that we get everything you say, we would like to tape-record the interview. The tape will be transcribed and then destroyed. We will use code to identify your contribution and your name will not be attached.

6. What are the possible disadvantages and risks of taking part?

It is unlikely that there will be any disadvantages in taking part in this training needs analysis – but sometimes people might have upsetting memories or thoughts. If this happens to you, you can stop the interview at any point, refuse to answer questions or take time to compose yourself etc. Although this will be handled sensitively within the interview, if you feel upset by anything, one of the facilitators will be available to meet with you afterwards.

7. What are the possible benefits of taking part?

Whilst there are no direct benefits for taking part in this project, some participants may find it helpful to talk to the training team or indeed to address issues from their experiences by discussing them openly within an interview. Additionally, some participants may like to be involved in a project that will be used to inform the development of manual restraint training in order to support 'best practice'.

8. Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the training needs analysis will be kept strictly confidential and will comply with the data Protection Act. Any information about you which is used will have your name and all other personal details removed so that you cannot be recognized from it. We will not ask for your personal details such as name, gender etc. You will not be identified in the project report.

9. What will happen to the results of the training needs analysis?

The results or findings of the project will be used to review the physical intervention training offered to Camden & Islington Trust staff with the aim of reinforcing 'best practice'. The study will also be used for the partial fulfillment of Master in Professional Studies.

Appendix C (cont'd)

10. Who has reviewed the project?

This training needs analysis will be reviewed by the Middlesex University Health Studies Ethics Sub-Committee (HSESC)

If you wish, a printed summary of the report will be available from November 2012. My contact is as shown below. Please leave your contact details if there is no answer and I will call you.

11. Contact for Further Information:

Jane Obi-Udeaja
Lecturer and GSA Tutor
Dept of Mental Health, Social Work & Inter-Professional Learning
Middlesex University
Clerkenwell Building
Archway campus
10 Highgate Hill
LONDON N19 5LW

E-mail: J.Obi-Udeaja@mdx.ac.uk
Tel: 020 8411 4911

Thank you for taking the time to read this information sheet and for considering whether or not to take part in the project.

Appendix D

Participant Identification Number:

CONSENT FORM

Title of Project:

An exploration of patient centred manual restraint in mental health wards: a phenomenological study

Name of Researcher: **Jane Obi-Udeaja**

Please initial box

1.	I confirm that I have read and understand the information sheet datedfor the above study and have had the opportunity to ask questions.	<input type="checkbox"/>
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.	<input type="checkbox"/>
3.	I understand that my interview may be taped and subsequently transcribed	<input type="checkbox"/>
4.	I understand that all information that is collected about me during the course of this study will be kept strictly confidential	<input type="checkbox"/>
5.	I agree to take part in the above study.	<input type="checkbox"/>

Name of participant

Date

Signature

Name of person taking consent
(if different from researcher)

Date

Signature

Researcher

Date

Signature

1 copy for participant; 1 copy for researcher;

Appendix E



North Central London
Research Consortium

North Central London Research Consortium
3rd Floor, Bedford House
125 - 133 Camden High Street
London, NW1 7JR

23rd July 2012

Jane Obi-Udejaja
Lecturer and GSA Tutor
Department of Mental Health, Social Work &
Inter-professional Learning
Middlesex University
Clerkenwell Building
Archway Campus
10 Highgate Hill
London
N19 5LW

Dear Jane,

Study Title: The use of patient centred manual restraint in mental health wards- A training needs analysis

Thank you for submitting and registering the above project. Projects are registered with the North Central London Community Research Consortium if they utilise patients, staff, records, facilities or other resources of **Camden & Islington NHS Foundation Trust**.

As we deem your study as a service evaluation, you will not need to register with us, nor gain the research ethics committee favourable opinion, nor seek our permission for commencement of this project.

I wish you every success with your research

Yours sincerely


Senior Research Governance Officer

Appendix F

Jane Obi-Udejaja

From: [REDACTED]
Sent: 26 April 2012 16:19
To: Jane Obi-Udejaja
Cc: [REDACTED]
Subject: RE: Application for ethical approval

Dear Jane

Re: A1 application 897

Thank you for the information which you submitted to the ethics sub-committee (health studies) regarding the above project.

I can confirm that since your project was categorised as A1 (Literature Review) and does not formally require ethical approval, your application will be logged on our database for information only.

[REDACTED] BA (Hons)
Department & Programmes Administrator
Health Studies Ethics Committee Secretary London Sport Institute & Initial and Acute
Nursing Practice Department Middlesex University The Burroughs London NW4 4BT
Tel: 020 8411 6261
Email: c.allison@mdx.ac.uk

-----Original Message-----

From: Jane Obi-Udejaja
Sent: 25 April 2012 19:00
To: [REDACTED]
Cc: [REDACTED]
Subject: Application for ethical approval

Hi [REDACTED],

Attached please are my completed forms for the approaching Health Studies Ethics Sub-Committee meeting.

Thanks and regards

Jane

Appendix G

Jane Obi-Udejaja

From: [REDACTED]
Sent: 16 April 2012 18:31
To: Jane Obi-Udejaja
Cc: [REDACTED]; [REDACTED]
Subject: [SPAM: 17.100] RE: Mental Health & LD Research & Practice Journal

Dear Jane

Thanks you for your email and the description of your proposed study.

It looks like the project could be approved as a training needs analysis, or a piece of service evaluation. The best thing to do here would be to send a copy of the project protocol, including your methods, aims and proposed use of data from the study, to the ethics committee administrator. You should include any copies of semi-structured interview schedules you wish to use for individual interviews with staff, or guides for focus groups, and information sheets. For approval as audit you need to emphasise that no identifying data will be sought or recorded from staff in terms of their demographics. *

You should ask her to pass your request on to the Chair of the ethics committee for consideration for approval as a training needs analysis. If the Chair deems it suitable, it will be passed without you submitting a full ethics application via IRAS. You will be given a letter to confirm that the ethics committee have approved your audit/evaluation to be conducted.

The ethics administrator for North London is Louise Braley- email louise.braley@nhs.net

Please let me know if you need any further assistance with this

Best wishes

[REDACTED]

[REDACTED]

*Deputy Director of Nursing
Camden and Islington NHS Foundation Trust
St Pancras Hospital
4, St Pancras Way
London
NW1 0PE*

Tel: 07958 269245

From: Jane Obi-Udejaja [j.obi-udeaja@mdx.ac.uk]
Sent: 16 April 2012 17:26
To: [REDACTED]
Cc: [REDACTED]; [REDACTED]; [REDACTED]
Subject: FW: Mental Health & LD Research & Practice Journal

Good afternoon [REDACTED],

My name is Jane Obi-Udejaja. I am a full time teaching staff of Middlesex University. I am one of the tutors who facilitate the Therapeutic Management of Violence and Aggression courses (TMVA) for Camden and Islington staff. I have been playing the lead role in my team's research studies for the continuing improvement of our (TMVA) training service.

The loop below explains an earlier discussion with Jo Spencer who I understand is currently unavailable regarding my current interest to work collaboratively with C&I mental health inpatient ward staff to explore their use of patient centred physical restraint approaches as practised in training.

Appendix G (cont'd)

Focus groups and semi-structured interviews will be used to gather information on ward staff perspectives regarding patient centred physical restraint as practiced in their respective wards.

Jo had suggested identifying and working with two wards – one from High Gate and the other from St Pancras.

The outcome of the study will be looped back into the TMVA training provision for the Trust and for a partial fulfilment of Masters in Professional Studies.

My Departmental Programme Director ~~Janet H. Johnson~~ informed me that you are the best person to talk to for support and advice regarding sorting out permissions and approval for this. Is this something that would need NHS research ethics approval or would it be more appropriately considered as a training needs analysis?

I look forward to your favourable response.

Many thanks

Jane. Obi-Udeaja

From: ~~Paul Simon [mailto:Paul.Simon@cardinal.ac.uk]~~
Sent: 23 May 2011 17:05
To: Jane Obi-Udeaja
Subject: [SPAM: 6.600] RE: Mental Health & LD Research & Practice Journal

I met with Jo this afternoon – she is very keen – and felt like you that perhaps one ward at the HMHC and one at the SPH site would be the way to go. Jo will get back to you – she did mention ethics? I'm sure you're well versed in these procedures.

~~Simon~~

From: Jane Obi-Udeaja [mailto:j.obi-udeaja@mdx.ac.uk]
Sent: 23 May 2011 13:41
To: ~~Paul Simon~~
Subject: RE: Mental Health & LD Research & Practice Journal

Immense thanks ~~Simon~~

Jane

From: ~~Paul Simon [mailto:Paul.Simon@cardinal.ac.uk]~~
Sent: 23 May 2011 13:20
To: ~~Paul Simon [mailto:Paul.Simon@cardinal.ac.uk]~~
Cc: Jane Obi-Udeaja
Subject: FW: Mental Health & LD Research & Practice Journal

~~Paul Simon~~ – I'd like to introduce Jane to you both – she is about to undertake a doctorate in TMVA – and needs a couple of clinical environments to help with her research – could we discuss further?

~~Simon~~

From: Jane Obi-Udeaja [mailto:]
Sent: 23 May 2011 10:10

Appendix: H

Table 3: Question (Q) numbering, Categorizing and Coding

Focus Group 3

Participants: Florence, Nicky and Steve

Q No.	Speaker	Comment	Meaning unit	Category	Code
1.	Interviewer:	<i>What do you understand by manual restraint of patients?</i>			
	Steve:	...it means going in as a team to restrain or hold a patient who is agitated, to maintain safety in the ward. It is usually a last resort option ...	restrain or hold a patient to maintain safety last resort option	Physical restraint is for maintaining safety	A
	Florence:	... holding a patient to control an aggressive behaviour and trying to de-escalate the situation ...	holding a patient to control behaviour de-escalate the situation	Physical contact is involved	AA
	Nicky	...using the control and restraint technique to manage an aggressive or violent situation... It is a last resort option to de-escalate a situation and maintain a safe environment .	manage an aggressive or violent situation last resort maintain a safe environment	Physical restraint is for maintaining safety	A
2.	Interviewer:	<i>How do you restrain your patients in a therapeutic or patient catered manner?</i>			
	Florence	We talk to the patient and inform him/her of what we are doing. Explain why we are using 'control' and restraint	Talk to the patient and inform Explain	Communicating with the patient	G G
	Steve	Involve staff that are familiar with patient	Involve staff that are familiar with the patient	Getting a colleague with whom the patient relates well	II
	Nicky	Be mindful of gender issues	Be mindful of gender issues	Gender issues	Q
	Florence	Use minimum force	Use minimum force	Non-pain compliant holds	O
Nicky	Reassure patient through the process	Keep reassuring patient	Restraint can only be therapeutic or punitive	N	

3.	<p><i>Interviewer:</i> Can you give examples of how you have used patient caring restraint strategies?</p> <p>Steve</p> <p><i>Interviewer:</i> What kind of behaviour was patient exhibiting?</p> <p>Florence</p> <p><i>Interviewer:</i> How was the incident de-escalated?</p> <p>Florence</p> <p>Nicky</p>	<p>In a recent restraint incident involving my primary patient, I took over from a restraint member about whom the patient was agitating.....</p> <p>...started banging on the door very agitated and wanted to punch staff.</p> <p>Two staff took the patient to her bedroom using figure four hold and seated de-escalation. They made it clear to her that the behaviour was unacceptable and offered alternatives to her. She calmed down eventually...</p> <p>We use minimum force depending on the level of agitation. For example when leave was not granted to a patient. She wanted to throw and break objects (furniture). Staff used 'fig 4' holds and seated de-escalation and managed to calm her down...</p>	<p>I relieved a restraint member about whom the patient was agitating.</p> <p>'Fig 4' hold and seated de-escalation They made it clear to her... offered alternatives to her</p> <p>We use minimum force...</p> <p>'Fig 4' holds and seated de-escalation De-escalated and managed to calm her down...</p>	<p>Trigger removed is T</p> <p>Non-paint compliant holds Communicating with the patient Seeking alternatives</p> <p>Non-paint compliant holds Communicating with the patient</p>	<p>T</p> <p>O G P</p> <p>O G</p>
4.	<p><i>Interviewer:</i> How about team work?</p> <p>Florence</p>	<p>... one person leads during the process ...checking physical state...</p>	<p>A lead person check physical state</p>	<p>A lead person</p>	<p>B</p>
5.	<p><i>Interviewer:</i> What are the advantages of patient sensitive practices during restraint?</p>			<p>Risk</p>	

	Nicky Steve Florence	...Minimizes risks... ...Patient feels that staff care about him/her... ...Quick retrieval of relationship.. ...safe manner to maintain relationship...	Minimizes risks Patient feels that staff care Quick retrieval of relationship..	minimization Quick retrieval of relationship	K K
6.	<i>Interviewer:</i> Steve Florence <i>Interviewer:</i> Florence <i>Interviewer:</i> Florence	<i>Any problems with the approach?</i> Staff shortages Getting restraint staff from other wards... ... such staff may use non-patient sensitive strategies... <i>How would you describe such strategies?</i> ..Insensitivity, poor communication... <i>How might you deal with such staff?</i> ... may be ask another staff to take over – may be address it during debriefing...	Staff shortages Emergency response team	Shortage of staff Emergency response team	L L
7.	<i>Interviewer:</i> Steve Nicky	<i>Could you have done anything differently in the scenarios?</i> Coming back freshly from an update once, I was able to respond very effectively and to support other team members with the correct way to carry out the process.	freshly updated ... responded effectively and supported others	Training	C
8.	<i>Interviewer:</i> Florence	<i>You earlier mentioned debriefing – Do you debrief after restraint incidents?</i> It depends on staff – their beliefs and practice. I always do so. It is important to check that			

	<p>everybody is fine and calm. Some staff don't bother with debriefing. But then shortage of staff makes it difficult. So there is official and unofficial debriefing, official for serious incidents and unofficial where members just ask 'Are you alright?' even as they are dashing back to their posts.</p> <p><i>Interviewer:</i> Nicky <i>What about the patients – Do you debrief them?</i> Always. ... When the situation has calmed down, a staff member sits with patient to examine the incident and to consider how it could have been prevented.</p>	<p>Some staff don't bother with debriefing. But then shortage of staff makes it difficult.</p> <p>Always debrief When the situation has calmed down staff sit with patient to examine the incident</p>	<p>The importance of debriefing</p> <p>Shortage of staff</p> <p>The importance of debriefing Right time for debriefing</p>	<p>F</p> <p>L</p> <p>F</p> <p>FF</p>
9.	<p><i>Researcher:</i> Steve <i>Did participating in the restraint of your primary patient cause you concern?</i> Initially I kind of thought 'hmm' should I really? But then I did and I was quite comfortable with that and so was my patient.</p>	<p>I was quite comfortable with that and so was my patient</p>	<p>Participating in the restraint of a primary patient</p>	<p>M</p>
10	<p><i>Colleague:</i> Florence Nicky</p>			

Key to the codes

Code	Category
A	Physical restraint is for maintaining safety
AA	Physical contact is involved
N	Restraint can only be either therapeutic or punitive
H	Knowing the patient
J	Awareness of cultural
I	The importance of building a rapport with the patient
P	Seeking alternatives

X	Involving the patient
II	Getting a colleague with whom the patient relates well
T	Trigger is removed
BB	Non-threatening stance
B	Lead person
GG	Tone of voice
GGG	Clear command
O	Appropriate and non-pain-compliant holds
Q	Gender issues
G	Communicating with the patient during restraint procedure
D	Knowledge of team members' strengths and weaknesses
U	Co-ordinating the process
L	Poor assessment of the situation
L	Injury during the procedure
L	Shortage of staff
L	Emergency staff system
R	Restraint and emotion
T	An assaulted team member is removed
M	Participating in the restraint of a primary patient
F	The importance of debriefing
FF	Right time for debriefing
K	Physical intervention is helpful
K	Risk minimization
K	Quick retrieval of relationship
K	It calms the ward
K	Patient is grateful in the end
V	Delayed intervention
V	Reluctance to take control
V	Differences of opinion
C	Training
CC	Intensive role play
CCC	Team training
Y	Sustainability of patient centred restraint
Z	Non-involvement of allied professionals

Appendix: I

Table 4: Categories identified in the data sets (at a glance view)

Category	Code	Fg1	Fg2	Fg3	Fg4	Ss1	Ss2
Physical restraint is for maintaining safety	A	×	×	×	×	×	×
Physical contact is involved	AA			×		×	×
Restraint can only be either therapeutic or punitive	N	×		×	×	×	×
Knowing the patient	H	×	×				
Awareness of cultural issues	J	×					
The importance of building a rapport with the patient	I	×	×			×	×
Seeking alternatives	P	×	×	×	×		×
Involving the patient	X				×		×
Getting a colleague with whom the patient relates well	II	×	×	×		×	
Trigger is removed	T			×		×	×
Non-threatening stance	BB	×					
Lead person	B	×		×	×		
Tone of voice	GG	×	×		×		
Clear command	GGG	×					
Appropriate and non-pain-compliant holds	O	×	×	×	×	×	×
Gender issues	Q	×		×			
Communicating with the patient during restraint procedure	G	×	×	×	×	×	×
Knowledge of team members' strengths and weaknesses	D	×	×				×
Co-ordinating the process	U					×	×
Poor assessment of the situation	L	×					
Injury during the procedure	L	×					
Shortage of staff	L	×	×	×		×	
Emergency response team	L	×	×	×		×	
Restraint and emotion	R				×	×	×
An assaulted team member is removed	T					×	×
Participating in the restraint of primary patient	M	×		×			
The importance of debriefing	F	×	×	×	×	×	×
Right time for debriefing	FF	×	×	×	×	×	×
Physical intervention is helpful	K	×	×		×		×
Risk minimization	K			×			
Quick retrieval of relationship	K	×	×	×	×		
It calms the ward	K		×				
Patient is grateful in the end	K	×	×	×	×		×
Delayed intervention	V						×
Reluctance to take control	V						×
Differences of opinion	V					×	×
Training	C	x	x	x	x	x	x
Intensive role play	CC						×
Team training	CCC	x					
Sustainability of patient centred restraint	Y						×
Non-involvement of allied professionals	Z						×

Appendix: J

Key to the codes

Code	Category
A	Physical restraint is for maintaining safety
AA	Physical contact is involved
N	Restraint can only be either therapeutic or punitive
H	Knowing the patient
J	Awareness of cultural
I	The importance of building a rapport with the patient
P	Seeking alternatives
X	Involving the patient
II	Getting a colleague with whom the patient relates well
T	Trigger is removed
BB	Non-threatening stance
B	Lead person
GG	Tone of voice
GGG	Clear command
O	Appropriate and non-pain-compliant holds
Q	Gender issues
G	Communicating with the patient during restraint procedure
D	Knowledge of team members' strengths and weaknesses
U	Co-ordinating the process
L	Poor assessment of the situation
L	Injury during the procedure
L	Shortage of staff
L	Emergency response team
R	Restraint and emotion
T	An assaulted team member is removed
M	Participating in the restraint of a primary patient
F	The importance of debriefing
FF	Right time for debriefing
K	Physical intervention is helpful
K	Risk minimization
K	Quick retrieval of relationship
K	It calms the ward
K	Patient is grateful in the end
V	Delayed intervention
V	Reluctance to take control
V	Differences of opinion
C	Training
CC	Intensive role play
CCC	Team training
Y	Sustainability of patient centred restraint
Z	Non-involvement of allied professionals

