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Nursing: violence, aggression, and containment measures

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This thesis has been submitted in partial fulfilment of the requirements
for the degree of Doctorate in Clinical Psychology

Coventry University, Faculty of Health and Life Sciences

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List of Abbreviations

A&E	Accident and Emergency
CASP	Critical Appraisal Skills Programme
CINAHL	Cumulative Index of Nursing and Allied Health Literature
CQC	Care Quality Commission
C&R	Control and restraint
DOH	Department of Health
ED	Emergency Department
HCA	Healthcare Assistant
IMI	Intramuscular Injection
LD	Learning Disability
MAPA	Management of Actual or Potential Aggression
MH	Mental Health
MHA	Mental Health Act
NA	Nursing Assistant
NICE	National Institute of Health and Care Excellence
NMC	Nursing and Midwifery Council
OD	Occupational Disappointment
PICU	Psychiatric Intensive Care Unit
PIS	Participant Information Sheet
PMVA	Prevention and Management of Violence and Aggression
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-analyses
RCN	Royal College of Nursing
RRN	Restraint Reduction Network
SNAP	Security Needs Assessment Profile
SPIDER	Sample, Phenomenon of Interest, Design, Evaluation, Research Type
SU	Service User
UCAS	Universities and Colleges Admissions Service
UK	United Kingdom
USA	United States of America
WPV	Workplace Violence

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Declaration

This thesis is an original piece of my own work, that has been submitted as part of the fulfilment of requirements for the degree of Doctor in Clinical Psychology, to the Universities of Coventry and Warwick. The work included in this thesis has not been submitted for any other qualification or to any other institution.

It was completed under the academic supervision of Dr Magda Marczak (Lecturer, Coventry University) and Dr Lesley Harrison (Assistant Professor, Coventry University). The supervisory process included support in the study designs, analyses, and the reading of, and feedback on, draft papers. In addition, a colleague also completed quality assessments on all included papers for the systematic review to ensure reliability of the process. With the exception of collaborations highlighted above, the content of this thesis is my own.

The systematic review (chapter one) has been prepared for submission to the *Journal of Emergency Nursing*.

The empirical paper (chapter two) has been prepared for submission to the *Journal of Psychiatric and Mental Health Nursing*.

Summary

This thesis focuses on nurses and their experience of violence and aggression and perceptions of containment measures.

Chapter one includes a meta-ethnographic review of qualitative research concerning general nurses' experiences of violence and aggression in the emergency department. Four meta-themes are identified and mapped onto Bronfenbrenner's (1979) ecological model to illustrate the complex relationship between nurses, their aggressors, and the interconnected societal factors perpetuating this relationship. Clinical implications and areas of potential intervention are discussed.

Chapter two details an empirical qualitative study capturing the perceptions that student mental health nurses (SMHNs) have about control and restraint (C&R). These interventions can be used in acute and secure mental health settings as a last resort to manage challenging situations. The interventions are known to be (re)-traumatising for all involved and cause internal conflicts for nurses who employ them. Currently SMHNs are somewhat protected from this reality as they are not trained fully in this process. Using an applied thematic analysis approach, 15 SMHNs were interviewed. Three distinct codebooks were identified, specifically highlighting 1) the *Context* in which SMHNs develop an understanding of C&R, how that relates to their career trajectory and the consolidation of their personal and professional identities, 2) perceived *Moral Dilemma* of engaging in C&R, and 3) perceptions of *The Aftermath* of engaging in C&R as a nurse. Recommendations for future practice are highlighted.

Chapter three is a reflective account (using Acceptance and Commitment Therapy [ACT] principles) of the research process undertaken to complete the presented thesis. It explores the lessons learnt as a practitioner, researcher, and individual.

Summary word count: 259

Thesis total word count: 19,823 (excluding figures, tables, footnotes, and references)

1.0. CHAPTER ONE

“On the front line with only... malfunctioning weapons”

A meta-ethnographic review of nurses' experiences of violence and aggression in the emergency department

This chapter has been prepared for submission to the *Journal of Emergency Nursing*
(see Appendix A for the journal's author instructions)

Word count: 7825 (exclusive of tables, figures, footnotes, and references)

ABSTRACT

Aim: The present meta-ethnography set out to synthesise qualitative empirical research investigating violence and aggression perpetrated against nurses in the Emergency Department (ED).

Methods: Four databases (CINAHL Complete, PsycINFO, Medline and ProQuest Dissertations and Theses: UK and Ireland) were systematically searched using terms informed by the aim of the review. The search resulted in 17 studies which met the inclusion criteria and were considered relevant to the review aims.

Results: Analysis revealed four meta-themes: 1) Violence in the ED, 2) “Nobody cares, nothing changes”, 3) Peers and patients, and 4) “On the front line with only... malfunctioning weapons”, which were mapped onto Bronfenbrenner’s (1979) ecological model.

Conclusions: The findings have important clinical implications for both policy and practice. In particular, they suggest a systematic approach targeting each level of the ecological system is warranted to reduce violence and aggression perpetrated against nurses in the ED. Future research directions are also indicated.

Abstract word count: 152

Key words: violence, aggression, workplace violence, emergency department, nurse, meta-ethnography

1.1. INTRODUCTION

1.1.1. Review subject and significance

Nurses are frequently subjected to workplace violence (WPV; Chapman et al., 2010). The issue of aggression and violence perpetrated against nurses has only relatively recently been acknowledged at an international level (Holmes, 2006). This followed a World Health Organisation (WHO; Di Martino, 2002) report that synthesised country-specific case studies focusing on the growing phenomenon of violence perpetrated against those working in healthcare settings.

The Emergency Department (ED) is a high-pressure environment, characterised by uncertainty and life-or-death decision-making (Yuwanich et al., 2017). Nurses also contend with patients accessing the ED inappropriately; that is, when the patient perceives they have received inadequate treatment from non-urgent care providers (Dal Pai & Lautert, 2011, as cited in Midori Sakai et al., 2016).

Nurses in ED are particularly at risk when performing care tasks which involve encroaching on the patient's personal space usually before a therapeutic relationship has developed (Vandecasteele et al., 2015). In terms of proxemics (Hall, 1966) these tasks require the nurse to enter the patient's intimate or personal zones and so the nurses' vulnerability is increased. Close proximity especially with strangers and outside of intimate or invited contact, results in heightened arousal (McLaughlin et al., 2008). This can initiate a fight or flight response, precipitating violence enacted against the nurse.

The nursing profession has been socially constructed as lower ranking in the healthcare professional hierarchy (Najafi et al., 2018). This belief has been reinforced by 'higher-ranking' professionals such as doctors who put nurses in auxiliary, rather than autonomous, positions (Najafi et al., 2018). The stereotyping of nurses may contribute to their potential victim status– legitimising violence on account of perceived subservience of the nurse (Ferns, Cork, & Rew, 2005). Nurses in the ED are considered front-line staff who often intervene to prevent situations from deteriorating even at the expense of personal safety (Holmes, 2006).

Violence and aggression are socially constructed concepts: they are inconsistently defined person- and context- specific variables (Knowles et al., 2013). Violent behaviour may be constructed differently if the patient is perceived to be legitimately unwell with a diagnosis associated with increased risk of violence (Williamson et al., 2013), rather than acting under their own volition (Hogarth et al., 2016). In the context of a cultural tolerance for violence and aggression, nurses are challenged with providing care to potential, and actual, aggressors whilst maintaining safety of all in the vicinity (Morphet et al., 2014). Adopting the Delphi technique, Rodger, Hills and Kristjanson (2004) established that nurses with lived experience of working in the ED want research to prioritise understanding the increase of violence in the ED.

1.1.2. The impact of violence and aggression in the ED

The rate of violence and aggression perpetrated toward nurses is increasing (Virkki, 2008). Patient- and visitor- initiated violence perpetrated against nurses in the ED can be extreme, even fatal (Ferns et al., 2006). The inconsistent definition of violence and aggression may inherently lead to inadequate record-keeping of the

myriad of incidents that occur (Knowles et al., 2013). Nurses do not reliably (and formally) report such incidents for several reasons including inaccessible systems, concern that blame will be apportioned to them, and a perceived lack of meaningful change after reporting incidents (Virkki, 2008). It is also not unusual for nurses to be dissuaded from reporting by managers (Hogarth et al., 2016). Reported rates are, therefore, unlikely to be representative of the reality (Holmes, 2006).

The consequences of violence are extensive for the nurse, healthcare providers and the wider community (Hogarth et al., 2016). Violence perpetrated against nurses has been associated with intent-to-leave, and actual resignation from, the profession (Farrell & Bobrowski, 2003). This finding is, however, inconsistent as Ogunidipe et al., (2013) report that nurses acknowledged they were not safe in their work in ED, but they did not wish to work elsewhere in the hospital. The plethora of responses to victimhood may indicate that the impact of WPV on nurses is likely to be idiosyncratic.

In the United States of America (USA), the cost of WPV is reported to extend beyond the cost of absenteeism to staff turnover, decreased workforce efficiency and psychological and physical care costs following the trauma (Renker et al., 2015). Matrix (2013) produced a European review of the financial societal impact of work-related depression (resulting from workplace stress) and estimated this to be €617 billion per year (as a result of social welfare payments, absenteeism, presenteeism, healthcare costs and diminished productivity). There are further costs related to litigation and consequences related to decreased patient satisfaction and attempts to restore the hospital's reputation (Renker et al., 2015).

Various strategies have been implemented to reduce WPV against healthcare professionals, with limited efficacy (Hogarth, et al., 2016). For example, despite the appeal of 'zero tolerance' policies, concerns were raised that such policies undermine professional judgement and promote systems which are management-led and rigid (Holmes, 2006). It was argued that nurses would be perceived as less competent at making in-the-moment decisions about how to manage (potential) violence and aggression because of these policies (Holmes, 2006).

Despite research and political interest, it seems the rhetoric of reducing violence and aggression in the ED has not translated into meaningful change (Morphet et al., 2014): nurses continue to be vulnerable.

1.1.3. Summary of previous reviews

Several systematic reviews have been published in the past decade focusing on violence perpetrated toward healthcare professionals. All the reviews mentioned here have included studies from around the world, indicating that violence in healthcare is a global issue (Taylor & Rew, 2010). Lanctôt and Guay (2014) focused their review of 68 quantitative articles (published between 1985 and 2012) specifically on the consequences of WPV toward healthcare professionals. This review identified seven key consequences of violence against healthcare staff including the personal impact of psychological and physical trauma, and patient-related impacts concerning quality of care. The review identified a need for more specific research including exploration of gender differences in, and the longitudinal effect of, becoming a victim of WPV.

Taylor and Rew's (2010) review of 16 studies identified the characteristics of intervention studies. The review included all healthcare professionals in the ED. It highlighted the lack of consistent definitions of violence and aggression, and inconsistent measuring instruments across studies, for establishing the frequency and impact of WPV.

Two reviews synthesised qualitative data concerning violence perpetrated toward healthcare professionals in the ED. Ashton et al. (2018) conducted a meta-ethnography of the experiences of all healthcare professionals in respect to visitor- or patient-initiated violence in the ED and Triage area. The 12 studies included were conducted worldwide and it is unclear what timeframe was imposed for the review. Four key themes were established including the shared understanding that violence is inevitable, that staff make judgements about victimhood, that the experience is isolating, and that staff identify as "wounded heroes" (Ashton et al., 2018, p.17). It was concluded that EDs require an organisational change, focused on reducing violence and aggression by supporting staff with meaningful supervisory support and training.

Pich et al. (2010) reviewed qualitative research concerning patient-initiated violence perpetrated against nurses in the ED. Whilst the review's focus was on ED experience, it included experiences from other associated fields including mental health nursing where the researchers deemed these accounts to be relevant. Policy and position papers were also included. Three overarching themes were identified: risk factors, consequences, and impact of violence and preventative or management strategies.

It is evident that a more specific review (in terms of clinical area and profession) is required. A refined focus facilitates more meaningful inferences about violence and aggression directed toward nurses in the ED. Consequently, more appropriate policy and practice recommendations can be made.

1.1.4. Rationale and aim

It is proposed that the dismissal of qualitative research in systematic reviews leads to a misrepresentation of the evidence base (Atkins et al., 2008). Qualitative research is important in formulating the complexities of issues like violence and aggression (Whittington & Winstanley, 2008). It is appreciated that the value of qualitative synthesis has been debated in the literature due to the challenges of making inferences from context-specific data (Bearman & Dawson, 2013). However, the consistent levels of under-reporting of violence experienced by nurses (Virkki, 2008) render quantitative synthesis somewhat unhelpful clinically.

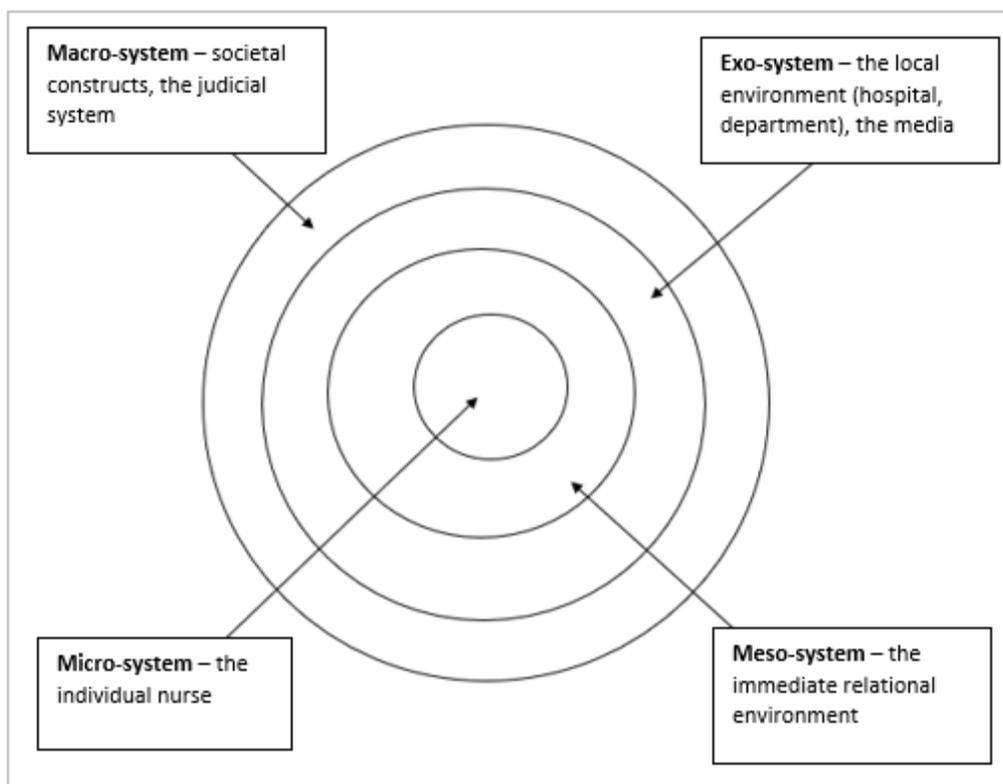
The aim of this meta-ethnographic synthesis is, therefore, to extend existing reviews of the literature by answering the question: *What are nurses' experiences of violence and aggression in emergency departments?*

Given the complexity of the topic, Bronfenbrenner's (1979) ecological systems model is used to illustrate the different layers of the themes that emerged from the meta-ethnographic analysis. This is similar to the Portuguese case study prepared for the WHO (Di Martino, 2002) which conceptualised a model based on an interactive

analysis of the personal, occupational, and environmental factors responsible for violence.

Bronfenbrenner (1979) proposed a nested model (Figure 1): at the micro-system level, there is an individual who is influenced by, and able to influence (to greater and lesser extents) the relational and structural environment around them. Presently, the micro-system is the individual nurse. Levels more disparate from the individual represent systems with which the nurse has a reduced degree of reciprocal interaction. At the meso-system, the immediate relationships available to the nurse are considered; namely, patients and the nurses' peer group. The exo-system in the current meta-ethnography is comprised of the media and the nurse's personal work environment. The macro-system represents the societal and judicial context.

Figure 1. Ecological system model (Bronfenbrenner, 1979)



1.2. METHODS

1.2.1. Systematic literature search

1.2.1.1. Database search

An initial scoping exercise to establish feasibility of the project (using two databases) was conducted between July and October 2019. Following ethical approval from Coventry University Ethics Committee (Appendix B) an electronic literature search was conducted in November 2019 using Cumulative Index to Nursing and Allied Health Literature Complete (CINAHL Complete), PsycINFO and Medline databases. These profession-congruent databases are also consistent with relevant previous literature reviews (Lanctôt & Guay, 2014; Pich et al., 2010; Taylor & Rew, 2010). ProQuest Dissertations and Theses: UK and Ireland database was searched for research covering the topic area. One thesis had subsequently been published and was considered for the current review due to meeting the inclusion criteria.

1.2.1.2. Search terms and strategy

To maintain the integrity of the search process and ensure terms were not influenced by prior knowledge (Butler et al., 2016), the search terms and strategy were established at the outset.

Consultation with the subject librarian was utilised to determine relevant terms (Table 1). Search terms were sought in the title, abstract, key words and subject of the articles to enhance the probability of identifying relevant studies.

Table 1. Search terms

Concept	Synonyms
Nurse	Qualified nurse, general nurse
Violence or aggression	Hostility, harassment, assault
Interpretivist designs	Questionnaire, survey, interview, case study, observation, focus group
Experience	View, opinion, attitude, perception, belief
Qualitative research	Qualitative, mixed methods

The concepts were established using the SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research Type) principles. A Boolean search strategy using the SPIDER principles (Cooke et al., 2012) was employed (Table 2) to configure the concepts.

Table 2. SPIDER principles and associated search strategy with truncations and Boolean operators.

SPIDER Principle	Main Concept	Terms to be used in current search strategy	Location
Sample (S)	Nurse	"nurse" OR "qualified nurse" OR "general nurse"	Title Abstract Key Word Subject
Phenomenon of Interest (P of I)	Violence or Aggression	"violen*" OR "aggress*" OR "hostil*" OR "harass*" OR "assault*"	Title Abstract Key Word Subject
Design (D)	Interpretivist designs	"questionnaire*" OR "survey*" OR "interview*" OR "case stud*" OR "observ*" OR "focus group*"	Title Abstract Key Word Subject
Evaluation (E)	Experience	"view*" OR "experienc*" OR "opinion*" OR "attitude*" OR "percept*" OR "belie*"	Title Abstract Key Word Subject
Research type (R)	Qualitative research	"qualitative" OR "mixed method*"	Title Abstract Key Word Subject
Configuration for Boolean search strategy: [S AND P of I] AND [(D OR E) AND R]			

The configuration was consistently employed for every search to promote transparency for replication purposes (Caldwell et al., 2011; Butler et al., 2016). See Appendix C for examples of the completed search strategy implementation.

1.2.1.3. Eligibility criteria

The current review included 1) qualitative and the qualitative part of mixed methods empirical papers; 2) investigating the nurse's experience of violence within the ED; 3) written in English and 4) published between the years 2002 and 2019.

Each search result was initially screened to establish eligibility. The full list of inclusion and exclusion criteria can be found in Table 3. The rationale is detailed in Appendix D.

Table 3. Inclusion and exclusion criteria

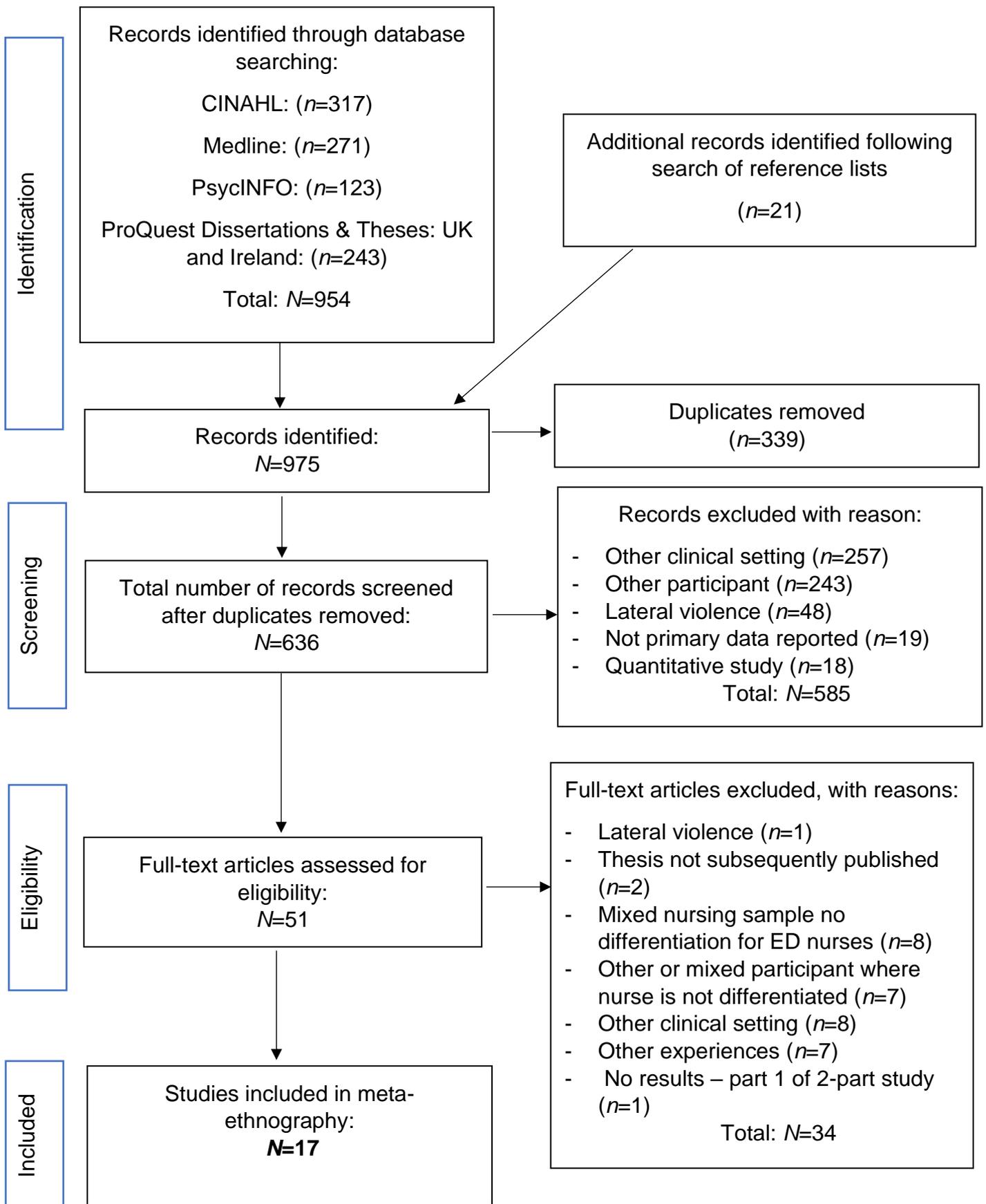
Criteria	Include	Exclude
Year of publication	2002 – 2019 (inclusive)	Prior to 2002
Language	English	All other languages
Nurse	Qualified General Nurse Mixed populations where general nurse data can be distinguished from the rest of the dataset	Nursing assistant, student nurse
Location of work	Emergency Department Accident and Emergency Triage	General wards Psychiatric wards Intensive care units High dependency units
Methodology	Qualitative data Mixed methods – qualitative data extracted	Quantitative data
Experience	Lived experience as victim Observation of violence and aggression toward colleagues Perceptions / attitudes regarding violence and aggression in the workplace	
Violence and aggression	Perpetrated by patient, their family members, or visitors Verbal and physical aggression Environmental aggression Sexualised behaviour Harassment	Patient to patient violence or aggression Nurse to nurse violence or aggression including bullying

1.2.2. Classification of studies

The Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) process has been used to illustrate the identification and selection

processes of potentially eligible literature. The completed PRISMA flow-diagram (Moher et al., 2009) is depicted in Figure 2.

Figure 2. PRISMA Flow Diagram (Moher et al., 2009)



Following the final database searches, 954 research articles were identified, and 21 additional records were identified through the manual review of reference lists. In total, 975 records were identified. After the removal of duplicate records, 636 remained.

At the screening phase, 585 records were excluded and during full text review, a further 34 records were excluded.

The current meta-ethnography included 17 studies.

1.2.3. Quality assessment

The current review used the Critical Appraisal Skills Programme (CASP, 1998) for quality assessment purposes. This framework consists of ten specific questions pertaining to the quality of information provided in empirical reports. The reviewer determines whether each criterion is adequately, partially, or not, fulfilled on a three-point scale. Each item was scored 0 for 'no', 1 for 'partially' and 2 for 'yes'. Total scores were converted to percentages.

1.2.3.1. Outcome of quality assessment

The overall quality of the studies included in this review ranged from 80% to 100%. Consistent with best practice, all the papers included in the systematic review were independently rated (Appendix E) by another reviewer (Butler et al., 2016). Inter-rater reliability analysis was conducted using the Kappa coefficient (Cohen, 1960).

Scores ranged from $\kappa=0.44$ to $\kappa=1.0$ and the overall score was $\kappa=.81$, indicating very good inter-rater reliability (Altman, 1999).

1.2.4. Method of synthesis

Meta-ethnography was chosen as the method of synthesis of qualitative data due to the inductive and interpretative process which emulates the data collection approaches of the studies being synthesised (Britten et al., 2002).

The current meta-ethnography followed the four-step process outlined by Atkins et al., (2008), detailed in Table 4.

Table 4. Summary of meta-ethnographic approach to data synthesis.

Stage	Description of process
Reading the studies	Akin to the studies being synthesised, the first stage in this process involved familiarisation with the data being synthesised. This was achieved through the reading and re-reading of the available data including reported themes (for first order constructs) and the discussion and conclusions (for second order constructs). Following this, preliminary metaphors and themes were extracted.
Exploring how studies are related	The data was then explored as a collective dataset with themes and metaphors considered in terms of how they related to each other. Recurring themes were thickened during this synthesis. During this stage of the process, more generic themes were mapped out to avoid the over-generalisation or minimisation of infrequently occurring themes. As the analysis continued, more meaningful themes emerged.
Exploring how study themes map onto each other	An index paper was established by reviewing papers in chronological order. Each paper went through a process of comparison of respective themes, concepts and metaphors. As appropriate, themes were synthesised to create new, more meaningful themes. New themes then became the reference theme for all subsequent papers reviewed against it. These themes were considered third order themes. It was important to retain the context of papers as the themes were combined across studies. This was hindered by limited contextual information reported in the primary data. This limitation was overcome by using the political and professional context of the subject matter as a frame of reference of emerging themes.
Synthesis of emerging themes through distillation	In the final stage, the analysis moved from descriptive to explanatory analysis: third order interpretation became a line of argument synthesis. This stage was facilitated using the research supervisory team to explore the relationship between themes and to consider a conceptual framework for expressing the findings of the analysis. The outcome of this analysis elucidated a new way of conceptualising the data and highlighted hypotheses which may be tested in future research.

1.3. RESULTS

1.3.1. *Characteristics of the literature*

The characteristics of the literature included in the current meta-ethnography are depicted in Table 5. Included studies were predominantly conducted in the USA ($n=5$) and Australia ($n=5$). Studies from Italy ($n=2$), Iran ($n=1$), Northern Ireland ($n=1$), Republic of Ireland ($n=1$), Singapore ($n=1$) and Taiwan ($n=1$), were also included. Three different types of healthcare systems are represented in the review: universal government funded¹, universal government insurance² and non-universal insurance³. Six authors (Gillespie, Pich, Hazelton, Kable Ramacciati, Ceccagnoli, & Addey) are co-authors on more than one paper: this may indicate researcher dominance in the field.

¹ Under this system, healthcare is provided universally to the citizens of that nation regardless of employment status. This is the modal healthcare system represented in the meta-ethnography presented here and includes Australia, Italy, Northern Ireland, Republic of Ireland & Taiwan

² This system describes healthcare which is provided free at the point of access if the individual is employed (a social insurance policy). Those not employed may be required to pay for their healthcare. From the current meta-ethnography this includes Iran and Singapore.

³ This refers to healthcare provided through private insurance. Some individuals in that country may not have insurance and therefore would need to pay for their treatment as required. Some individuals may be entitled to subsidies related to their insurance premiums. The USA is the only example of this healthcare system in the current meta-ethnography.

Table 5. Characteristics of the literature

Authors, study date and country Quality assessment (QA) & Inter-rater Reliability rating (Kappa Co-efficient; κ)	Research aims	Study design Sampling method	Sample size, recruitment and participants	Method of data collection Method of data analysis	Key findings
Angland, Dowling, & Casey 2014 Republic of Ireland QA: 85% $\kappa=1.0$	To determine nurses' perceptions of the factors causing violence and aggression in the ED.	Qualitative descriptive approach Purposive sampling	N=12 emergency nurses (3 men, 6 women) with at least 6 months experience in ED, who had been involved in an aggressive or violent incident within the month preceding participation.	Semi-structured individual interviews tape-recorded and transcribed verbatim. Thematic analysis	Two main themes: 1. Environmental factors This included the nurses' perceptions of the impact of waiting times, lack of resources and lack of security measures 2. Communication issues This related to perceived challenges in communication within the profession, between professionals and between professionals and patients/ relatives. Communication difficulties were exacerbated by nurses' sense of fear and vulnerability.
Christie 2015 USA	To explore the lived experience of ED nurses who were the victim of violence from patients, and to understand their perceptions of post-incident managerial support.	Descriptive phenomenological approach Purposive sampling	N=13 emergency department nurses All participants were >18 years old and had been the victim of violence at work within the past two years and	Individual interviews, digitally recorded and transcribed verbatim. Content analysis with constant comparison	Three themes identified: 1. Do you care? This theme related to the nurses' experience of upper management as being limited with emotional support toward them as victims in contrast to immediate supervisors, who did provide this level of support. Participants felt that

<p>QA: 90%</p> <p>$\kappa=1.0$</p>			<p>subsequently returned to work.</p>		<p>management were mostly concerned with patient satisfaction.</p> <p>2. Can you protect me? Participants felt unsafe at work after experiencing violence. Participants reported that they believed themselves to be supported by their peers but not management. Participants called for Police intervention and support on shift, and a willingness for charges to be pressed against offenders.</p> <p>3. Can you empower me? Participants asserted a need for policies and procedures designed to protect nurses exposed to violence. Participants believed that this would bolster the likelihood of senior staff supporting nursing decisions around violence and aggression management.</p>
<p>Gillespie, Gates, & Berry</p> <p>2013</p> <p>USA</p> <p>QA: 85%</p> <p>$\kappa=1.0$</p>	<p>To describe workplace violence perceived as stressful by nurses in the ED who have experienced it.</p>	<p>Qualitative descriptive design</p> <p>Systematic random sampling</p>	<p>$N=177$ nurses in the ED (149 women, 23 men)</p> <p>3000 nursing members of the Emergency Nurses Association were contacted, resulting in a 5.9% response rate from nurses who provided direct patient care in the emergency department and were recently</p>	<p>Hand-written narratives following standardised instructions for completion. Narratives subsequently transcribed verbatim.</p> <p>Constant comparison analysis</p>	<p>Four themes emerged:</p> <p>1. Personal worker factors This theme was comprised of three categories: nursing role, nursing experience and nursing practice. Nursing role relates to the job the nurse was doing within that environment, with charge nurses identified to be more likely to be in a risky situation. Nursing experience was variably noted by participants, typically those with extensive experience referenced this. Nursing practice illustrated the specific tasks that a nurse needs to undertake which can leave them more vulnerable to violence.</p>

			exposed to violence in that role.		<p>2. Workplace factors Five categories represented this theme including: location of violence, workplace design, security devices and personnel, wait times and policies. Several locations were reported to be the site of violence including triage and hospital lobbies. Participants attributed safety and security to improved surveillance, often identifying this to be lacking before serious incidents. Participants deemed perpetrators to be more likely to be violent when exposed to long waits. Lack of policies to protect staff or lack of their enforcement further contributed to risk of violence.</p> <p>3. Aggressor factors Two categories emerged: the patient's chief complaint (including mental health crises, substance use and pain) and situational context (including patients in police custody, those with a history of violence, frequent users of the ED and patient death). Perpetrators were identified to be both the patient accessing the ED and those attending with them (friends and relatives).</p> <p>4. Assault situation Three categories of assault situation were identified: physical violence, threats of physical violence and intimidation.</p>
Han, Lin, Barnard, Hsiao, Goopy, & Chen	To understand personal and professional responses of ED nurses who	Interpretative phenomenographic approach	N=30 registered nurses providing care in the ED (5 men, 25 women)	Individual semi-structured interviews which were audio-recorded and	<p>Four categories of description identified:</p> <p>WPV was constructed as a serious, insidious and growing problem with</p>

<p>2017</p> <p>Taiwan</p> <p>QA: 95%</p> <p>$\kappa=1.0$</p>	<p>experience workplace violence (WPV).</p>	<p><i>Sampling method unspecified</i></p>	<p>All participants were also >20 years of age and had experienced violence in the ED and from three EDs in Taiwan</p>	<p>transcribed with non-verbal communication detailed alongside speech.</p> <p>Participants were invited to draw a picture to represent their experience; this was not mandatory and was completed by 6 participants.</p> <p>Phenomenographic analysis</p>	<p>important clinical, professional and personal implications.</p> <p>1. ED WPV is part of the registered nurse's job</p> <p>The frequency of abuse is so high that nurses have no option but to absorb, ignore or tolerate its presence. Nurses felt that the pressure of their role hindered their ability to directly deal with the experience in healthy ways.</p> <p>2. ED violence can pose a direct threat to a nurse's life</p> <p>Nurses were acutely aware of the risk to their lives working in the ED. The dominant approach to managing this was to deny injury as it was believed to be unavoidable and the potential consequences of acknowledging injury were widespread including physical, emotional and professional consequences for the victim. Participants carry physical and emotional scars from their experiences.</p> <p>3. ED violence in an ongoing nightmare</p> <p>WPV was an experience with longstanding consequences beyond the event – some participants experienced intrusive flashbacks. Participants were concerned about the safety of themselves and their families. Workplaces consequently were experienced as more unsafe for the nurses.</p>
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					<p>4. ED violence diminishes the desire to work in the area of emergency care</p> <p>Participants noted that violent patients resulted in the nurse being less willing to provide full care to that individual, opting instead to by-pass certain processes in order to facilitate faster discharge of the patient from the ED. Participants felt that their experiences impacted directly on their views, their practice and their ability to feel compassion for their patients' deteriorating health.</p>
<p>Hassankhani, Parizad, Gacki-Smith, Rahmani, & Mohammadi</p> <p>2018</p> <p>Iran</p> <p>QA: 100%</p> <p>$\kappa=1.0$</p>	<p>To establish a sense of the aftermath and consequences for a nurse in the ED after experiencing WPV.</p>	<p>Qualitative exploratory design</p> <p>Purposive sampling</p>	<p>$N=16$ nurses (9 men, 7 women) who experienced violence in the ED.</p> <p>All were recruited from 5 hospitals in Iran after study details were distributed by nurse managers.</p> <p>Recruitment ended at the point of data saturation.</p>	<p>Face-to-face in-depth semi-structured interviews digital voice recorded and transcribed verbatim.</p> <p>Content analysis</p>	<p>One main category: suffering nurses</p> <p>Nurses who work in EDs are frequently subjected to WPV. Four sub-categories were established.</p> <p>1. Mental health risks</p> <p>Nurses commented on their experience of stress, anxiety, depression, and emotional and behavioural health issues as a result of WPV.</p> <p>2. Physical health risks</p> <p>The physical problems identified by participants included sleep problems, physical injury (more consistently reported by male participants) and stress-related chronic conditions such as respiratory difficulties, migraines and loss of appetite.</p> <p>3. Threats to professional integrity</p> <p>Participants attributed WPV as a reason for not wanting to work as a nurse. Their experiences of WPV had a negative</p>

					<p>impact on their communication with colleagues and patients. Nurses were mindful of the potential for WPV to have the potential for patients to be put at risk, or for serious adverse events to happen. For example, nurses were concerned that WPV could result in poor concentration and subsequently poor patient care for others, not just the perpetrator.</p> <p>4. Threats to social integrity Participants' social lives were also impacted following experience of WPV. Workplace stress impacted on home lives through participants being aggressive toward others after WPV. The experience of processing WPV added further strain on the nurse's life for example attending the Police station or going to court.</p>
<p>Hislop & Melby 2003 Northern Ireland QA: 95% $\kappa=0.615$</p>	<p>To describe and explore the lived experience of ED nurses in one hospital.</p>	<p>Philosophy of phenomenology within a qualitative framework</p> <p>Random sampling of 26 nurses who volunteered to participate at one A&E site</p>	<p>$N=5$ A&E nurses with at least one-year experience in the setting.</p> <p>All participants were known to the researcher.</p>	<p>Interviews conducted in mutually agreed location, which were taped. A decision trail was maintained by the researcher, and a pilot interview was conducted ahead of data collection.</p> <p>Four-step process of data analysis as outlined by Giorgi (1985)</p>	<p>Three main themes identified:</p> <p>1. Why me? Participants reported feeling powerless and frustrated about their experience of WPV. Participants saw themselves working in a caring capacity, and whilst they could understand factors contributing to patient anger (e.g. long wait times), they could not comprehend why they were the target of violence. Participants felt embarrassed by the experience of WPV and noted the presence of audiences (the waiting room) as exacerbating this and contributing to a collective hatred toward the nurses. Nurses were angry about the way they were treated by patients and visitors.</p>

					<p>2. A sense of belonging Nurses valued the support provided by colleagues after incidents of WPV. Informal support such as chats during coffee breaks were deemed more important to nurses. The sense of belonging was a bidirectional relationship of nurses appreciating their colleague's support, and of them being able to provide this support when needed.</p> <p>3. A sense of isolation Nurses believed that higher management were not aware of the reality of ED nursing and the experiences that nurses in this environment frequently face. Staff felt alone in dangerous situations: their reporting via formal channels did not result in noticeable change or feedback to the nurse victims. Nurses also experienced fear, specifically of personal injury as a result of their experiences.</p>
<p>Howerton Child & Sussman</p> <p>2017</p> <p>USA</p> <p>QA: 90%</p> <p>$\kappa=1.0$</p>	<p>To determine patterns of behavioural and emotional responding of ED nurses who experience verbal violence in the workplace (from patient or visitor perpetrators).</p>	<p>Grounded theory</p> <p>Snowball sampling</p>	<p>N=28 ED Registered nurses</p> <p>Recruitment was supported by advertising the study through the hospital sites and social media.</p>	<p>Non-structured in-depth interviews were conducted with participants either in person, on the phone or via FaceTime. Interviews were all recorded and transcribed verbatim. Field notes were added concerning non-verbal communication</p>	<p>One main theme: Occupational disappointment (OD)</p> <p>OD refers to the experience of nurses who are subjected to verbal WPV and the consequent feeling of being disheartened by this treatment. This theme was comprised of two subthemes.</p> <p>1. Protecting and contributing influences of people to OD Participants experienced their peers as having a variable influence on their experience of verbal WPV. Three different personality types were identified: the</p>

				<p>noted during interview.</p> <p>Constant comparative analysis</p>	<p>calmer (relating to nurses who were adept at reducing the potential for conflict, diffusing the situation effectively), the escalator (who made situations worse, and increased the likelihood of a nurse experiencing verbal WPV) and the protector (those nurses who step in to support a nurse being targeted – especially if the victim is a more inexperienced nurse).</p> <p>2. Neutral influences to OD Neutral influences included management (presence and influence) and mandatory courses (which were perceived to have little efficacy).</p>
<p>Hyland, Watts, & Fry</p> <p>2016</p> <p>Australia</p> <p>QA: 95%</p> <p>$\kappa=0.474$</p>	<p>The study had two aims: 1) Identify the characteristics of and patterns of violence perpetrated in the ED reported via the incident reporting system and 2) explore the perceptions of nurses caring for aggressive and / or violent people.</p>	<p>Mixed-method – qualitative arm adopting thematic analysis</p> <p>Purposive sampling</p>	<p>$N=53$ registered nurses with at least one year of experience in ED (response rate of 66.2%). 48 respondents were women; 5 men.</p> <p>All nurses at the two hospital sites included in the study had access to the study materials and could complete and return these in their own time (via secure boxes on site).</p>	<p>Open-ended survey questions as part of a mixed methods study. All written responses were transcribed before analysis.</p> <p>Thematic analysis</p>	<p>Three themes presented:</p> <p>1. Increasing security Staff perceived their work environments to be unsafe and called for increased security to ease this. The benefits of security presence was also perceived to extend to reduced damage to property in the hospital.</p> <p>2. Open access Nurses perceived the ED to be a freely accessible environment, with multiple entries which contributed to greater vulnerability for the nurses. Nurses reported that this was specific to their own working environment and noted this was not consistently an issue with other EDs.</p> <p>3. Rostering imbalance Participants highlighted that under-staffing contributed to higher incidents of violence</p>

					in the ED with specific reference to evening and weekends having diminished workforce, placing staff working at these times at greater risk.
Lau, Magarey, & Wiechula 2012 Australia QA: 85% $\kappa=0.756$	To develop an understanding of the culture of violence in an ED.	Contemporary ethnography <i>Sampling not explicitly stated</i>	$N=34$ nurses who were involved in 34 reports of violence	34 face-to-face interviews were conducted with nurses within 103 violent incident questionnaires were completed by nurses A data analysis framework was adopted to assist in the analysis of data at item (domain), pattern (taxonomic and componential) and structural levels.	Three themes emerged: 1. 'Problems and solutions' This theme related to the way in which nurses experienced and managed violence in the ED. This (and nurses' ability to identify violence indicators) was influenced by the perceptions that nurses held about violence. 2. 'Requests and demands' This theme refers to the culture of the ED and how this directly affected the behaviour of nurses as well as those accessing the ED (patients and friends/relatives). Specifically, this concerned the types of requests made by patients and relatives, and the experience of having to wait for review and treatment. 3. 'Them and us' The final theme illuminates the reciprocal relationship between two distinct groups of people (nurses and the patients/ family members/relatives) concerning the perpetration and victimhood of violence. Behaviour from one party inevitably resulted in a behavioural response from the other.
Luck, Jackson, & Usher	To conceptualise how nurses in the ED ascribe meaning to individual acts of	Instrumental case study using mixed-	$N=20$ full-time or part-time registered nurses currently	16 semi-structured interviews were completed and digitally recorded.	During the study, 16 episodes of violence were observed by the researchers: none of these were formally recorded through the channels for incident reporting.

<p>2008</p> <p>Australia</p> <p>QA: 100%</p> <p>$\kappa=1.0$</p>	<p>violence perpetrated by patients and/ or visitors.</p>	<p>method approach</p> <p>Convenience sampling for nurse interviews</p>	<p>working in the ED (18 women; 2 men).</p> <p>All participants were recruited from one regional Australian ED.</p>	<p>13 informal field interviews were undertaken and digitally recorded.</p> <p>Other data included structured and unstructured participant observations and researcher journaling.</p> <p>Thematic analysis</p>	<p>Nurses instead were observed to make judgements about each episode of violence and this in turn influenced their response to the violence.</p> <p>Three themes were identified:</p> <p>1. Degree of personalisation of violence</p> <p>The first key factor associated with how ED nurses conceptualise and respond to violence was the degree of personalisation involved with the act. Violence interpreted by nurses as being directed toward them as a symbol of the system (or because that nurse just happened to be in the environment) was more tolerable than when it was directed to the nurse as a human being. When the violence was not person-focused, nurses were better able to manage the consequences of the violence for example they were less likely to take the experience home with them.</p> <p>2. Presence of mitigating factors</p> <p>Nurses identified extenuating and explanatory circumstances that were constructed as making sense of a person's violent behaviour. This subsequently shaped the meaning ascribed to the violence, and the response of the nurse who were subjected to it. Such factors included patients presenting with mental health difficulties, confusion, disorientation, substance use or withdrawal, or head injuries.</p>
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					<p>3. Reason for ED presentation Nurses categorised patients as either appropriately or inappropriately accessing the ED. Those deemed to be inappropriately accessing the ED included those who nurses perceived as having the social and financial resources to access another health provision such as their GP or a 24-hour medical centre. In addition, participants experience of violence was established to be influenced by their respective understanding of a patient's legitimacy in presenting at the ED. Those who present without legitimate cause and were violent toward staff were treated with firmer boundaries, with staff less tolerant of their behaviour.</p>
<p>Pich, Hazelton, Sundin, & Kable</p> <p>2011</p> <p>Australia</p> <p>QA: 90%</p> <p>$\kappa=0.44$</p>	<p>To describe the experiences of triage nurses who experienced violence perpetrated by patients whilst working in the triage area of the ED the previous month</p>	<p>Qualitative descriptive design</p> <p>Purposive sampling</p>	<p>$N=6$ registered nurses (4 women; 2 men) working in the triage area.</p> <p>Recruitment took place within one study site: ED of a regional tertiary referral trauma and teaching public hospital.</p>	<p>Semi-structured interviews were conducted, audio-taped and transcribed verbatim.</p> <p>Qualitative content analysis</p>	<p>Five common themes were described:</p> <p>1. Physical abuse Participants spoke about a variety of physically violent acts they had experienced including biting, spitting, and kicking, intimidation and having weapons used against them.</p> <p>2. Verbal abuse Participants were frequently sworn at and threatened by patients and relatives.</p> <p>3. The impact of violent behaviour, personal and professional Participants who were subjected to violence at work reported feelings of frustration and powerlessness. Participants experienced violence as a</p>

					<p>degrading act, which left them reluctant to return to their workplace.</p> <p>4. Antecedents and risk factors Intentional and unintentional violence were perceived differently by the nurses. For example, violence perpetrated by a patient with dementia was construed as resistance to care rather than intentionally violent behaviour. Intoxication, mental health diagnoses and long waiting times were risk factors that participants associated with increased risk of violence. Age was also a factor associated with increased risk – younger people were perceived by participants to view healthcare as a right not a privilege.</p> <p>5. Risk management strategies Participants identified that current recommendations from management focused more on reaction to, rather than proactive management of, violence. Such interventions included alarms, security presence and the design of the triage environment. Zero tolerance policies were discussed as being ineffective, with staff repeatedly tolerating abusive behaviour. Participants valued informal debriefing with colleagues and having a glass of wine after difficult shifts.</p>
Pich, Hazelton, & Kable 2013	To describe the experience of nurses in the ED who have experienced violence from young person patient perpetrators (aged between 16-	Qualitative descriptive design Purposive sampling	N=11 registered nurses who worked clinically in Australian EDs in the previous 6 months and had been a member of	Face-to-face and telephone semi-structured interviews were conducted, audio-taped and transcribed. Two	<p>There was one central emergent theme: Feeling unsafe at work</p> <p>The fear that nurses experienced was not only related to their own well-being, but to their colleagues and others in the ED. Participants were concerned that children</p>

<p>Australia</p> <p>QA: 95%</p> <p>$\kappa=0.474$</p>	<p>25) or the parents of paediatric patients in the ED.</p>		<p>College of Emergency Nursing Australia (CENA) in 2010.</p> <p>Participants were made aware of the study after participating in Part I where the current study was advertised at the end of the survey.</p>	<p>interview schedules were employed, tailored to the group of perpetrators being discussed (parents of paediatric parents or young adults)</p> <p>Content analysis</p>	<p>would deem violence perpetrated toward ED nurses to be appropriate after witnessing their parents behaving in this way. Participants shared experiences of attempting to have support from Police involvement, but this not leading to any charges against perpetrators. Participants were resigned to feeling fearful whilst working in the ED.</p> <p>Two main themes were identified.</p> <p>1. Behaviours This theme was comprised of two subthemes: <i>“performing” and attention-seeking behaviours by patients</i> (noisy patients, those using intimidation and being disruptive or demanding) and <i>episodes of violence: verbal abuse and physical violence</i>. The latter referred to the specific behaviours that nurses experienced.</p> <p>2. Antecedents This theme encapsulated two subthemes. The first <i>alcohol and substance use</i> highlight that people under the influence of substances were more likely to engage in attention-seeking behaviour.</p> <p>The second, <i>parental emotions: fear, anxiety, impatience, and lack of understanding/knowledge</i> illuminates the behaviour of parents accompanying paediatric patients to the ED.</p>
<p>Ramacciati, Ceccagnoli, & Addey</p>	<p>To investigate the feelings of nurses who experience</p>	<p><i>Design not specified: researching</i></p>	<p>$N=9$ (6 women; 3 men) nurses who work in the triage</p>	<p>One focus group involving all nine participants was</p>	<p>Ten themes were identified:</p> <p>1. Feeling vulnerable</p>

<p>2015</p> <p>Italy</p> <p>QA: 95%</p> <p>$\kappa=1.0$</p>	<p>violence in the triage area which was perpetrated by a patient or someone accompanying a patient.</p>	<p><i>team developed own theoretical basis</i></p> <p>Purposive sampling</p>	<p>area and had been subjected to violence in the workplace</p> <p>Participants were recruited from 6 EDs in Tuscany</p> <p>Potential participants were approached via telephone or email by a person who was not part of the research team</p>	<p>facilitated, recorded, and transcribed verbatim.</p> <p>Colaizzi method</p>	<p>Participants reported being left without an option for protecting themselves due to a lack of judicial support. There was an expectation that nurses had to accept violence in their work.</p> <p>2. Feeling alone and unsupported by management Participants expressed feeling as though they had no one to talk to about their experience. Participants felt that management were not listening to their experiences and that the welfare of nurses was less of a priority than the upkeep of the environment that they work within.</p> <p>3. Feelings of inadequacy and guilt Participants expressed feelings of guilt, and that they may speculate whether another colleague might have handled the situation differently and avoided being the victim of violence.</p> <p>4. Injustice Participants expressed frustration toward the perpetrators of violence. There was a conflict between the nurses' sense of themselves as having provided care to an individual, and the resultant violence sustained by that individual or their relatives.</p> <p>5. Long lasting effects Participants spoke about the emotional wounds they sustained after incidents of violence. The wounds were perceived to be long-standing, taking time to heal.</p>
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					<p>6. Fear Participants who experienced violence held fears of this event recurring.</p> <p>7. Inevitability There was consensus that in the triage area violence had become commonplace – it was believed to be unavoidable in several instances.</p> <p>8. Excuse Nurses asserted that some patients were excused for their violent actions (for example older people), whereas others were deemed culpable (those with mental health diagnoses and those who were intoxicated).</p> <p>9. Gender difference Male staff were perceived to be more able to justify defending themselves, and to do so in a manner that left them unscathed. Female staff were perceived to be more likely to be frightened and more likely to be a target than male colleagues.</p> <p>10. Self awareness Participants acknowledged that the behaviour of nurses can contribute to the likelihood of violence being perpetrated against them.</p>
Ramacciati, Ceccagnoli, Addey, & Rasero	To qualitatively capture nurses' perceptions of verbal and physical violence	Mixed-methods approach adopting the	N=265 (144 women; 119 men; 2 unstated) emergency nurses	Free text response to one open-ended question at the end of a longer survey,	<p>Four major themes emerged:</p> <p>1. The nurses' perceptions of physical and verbal aggression</p>

<p>2018</p> <p>Italy</p> <p>QA: 95%</p> <p>$\kappa=1.0$</p>	<p>in the ED as part of a wider national survey.</p>	<p>Global Approach to Violence towards Emergency Nurses (GAVEN) model</p> <p>Proactive sampling</p>	<p>who completed a free text response at the end of a longer quantitative survey.</p> <p>Participants were recruited from across Italy. 1100 participants responded to the invitation to complete the survey.</p>	<p>completed electronically.</p> <p>Analysis undertaken using van Kaam's method</p>	<p>Nurses reported that violence is frequently experienced, under-reported and poorly understood as a concept that nurses must manage.</p> <p>2. Precipitating factors Several factors influence the likelihood of a patient or visitor being violent such as nurse-related factors (including poor communication), patient-related triggers (including their understanding of ED use and lack of respect toward nurses, bad manners and cultural and social determinants) and organisational factors (such as managerial disinterest, a general under-estimation of the frequency of violence in the ED and understaffing).</p> <p>3. Consequences As a result of violence perpetrated against them, nurses felt alone and perceived themselves to experience secondary victimisation because of being cited as the trigger for the violence. Nurses reported burn out after experiencing violence and that they can feel at war with patients and their respective relatives or visitors.</p> <p>4. Solutions Nurses identified solutions across four subthemes: solutions for nurses, solutions for patients, organisational solutions, and environmental solutions.</p>
<p>Tan, Lopez, & Cleary</p>	<p>To qualitatively capture ED nurses' perceptions of managing patients</p>	<p><i>Design not specified</i></p>	<p><i>N=10</i> (8 women; 4 men) registered nurses working in</p>	<p>Interviews conducted one-to-one, audio-recorded and</p>	<p>Four themes were revealed:</p> <p>1. Impact of patients' aggressive behaviours on nurses</p>

<p>2015</p> <p>Singapore</p> <p>QA: 85%</p> <p>$\kappa=0.756$</p>	<p>who present at the ED and behave aggressively.</p>	<p>Purposive sampling</p>	<p>the ED for their entire career.</p> <p>Nurses were recruited from one ED at a major general acute hospital in Singapore.</p> <p>Participants were made aware of the study through flyers and staff briefings.</p>	<p>transcribed verbatim. Data collection and analysis were simultaneous and data collection ceased at the point of saturation.</p> <p>Thematic analysis</p>	<p>The impact of aggressive behaviour was both psychological and physical. Nurses reported that post-incident they were more likely to ruminate over what could have been done differently, to feel unappreciated in their work and to feel upset.</p> <p>2. Nursing assessment of aggressive behaviours</p> <p>Nurses' assessment of patients was influenced by their previous experience with aggressive patients generally, and the current patient's presenting information and clinical history and the frequency with which they attend the ED.</p> <p>3. Nursing management of aggressive behaviours</p> <p>Even following injury, nurses asserted the importance of maintaining a good standard of care for their patients and adhering to professional obligations. Caring for aggressive patients was experienced to be time-intensive and often meant that other patients had lesser input from the nurse than the nurse would like to have provided.</p> <p>4. Organisational support and responsiveness</p> <p>Nurses identified that debriefs after incidents were infrequently offered. Incidents perceived as routine (due to the frequency of their occurrence within the ED) were not addressed by management. Support from colleagues was more frequent and appreciated by nurses who experienced violence at work.</p>
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<p>Wolf, Delao, & Perhats</p> <p>2014</p> <p>USA</p> <p>QA: 80%</p> <p>$\kappa=0.804$</p>	<p>To understand the experiences of nurses who have been physically or verbally assaulted whilst providing care to a patient in the ED.</p>	<p>Qualitative descriptive exploratory design</p> <p><i>Sampling method unspecified</i></p>	<p>$N=46$ (37 women; 8 men; 1 gender unspecified) emergency nurses registered with the Emergency Nurses Association (ENA).</p> <p>All nurses had experienced verbal or physical assault perpetrated by patients or visitors whilst delivering care in the ED.</p> <p>Email advertising was used via the ENA website.</p>	<p>Participants completed a narrative account of their experience following a standardised question and prompts about what to include in the account.</p> <p>Narrative research and constant comparisons</p>	<p>Three broad themes emerged:</p> <p>1. Environmental This theme encapsulates the nurses experience of their physical environment, security and the institutional culture that they work within. This included their experience of engaging with judicial proceedings in relation to the assault(s) they had experienced whilst in work.</p> <p>2. Personal This theme illuminated the impact that violence had on participants including on job performance, the coping skills employed, and their personal feelings about the process of engaging with law enforcement or the institutional environment.</p> <p>3. Cue recognition This theme described the antecedents that nurses perceived to contextualise their experience of violence. This included both recognised and unrecognised features and events including characteristics of both the environment and the aggressor.</p>
<p>Wright-Brown, Sekula, Gillespie, & Zoucha</p> <p>2016</p>	<p>The aim of the qualitative arm of this study is to describe the experiences of registered nurses injured by interpersonal</p>	<p>Mixed method study with convergent parallel design. Qualitative arm adopted Husserl's</p>	<p>$N=12$ (10 women; 2 men) registered nurses who had experienced interpersonal violence whilst working in the ED.</p>	<p>Semi-structured interviews conducted either face-to-face or via telephone. Interviews were all recorded and transcribed.</p>	<p>Four major themes established:</p> <p>1. Safety/security status The ED was believed to be a place where violence was increasingly occurring and beginning to be an accepted part of the role for nurses.</p>

<p>USA</p> <p>QA: 100%</p> <p>$\kappa=1.0$</p>	<p>violence whilst working in the ED.</p>	<p>phenomenological approach</p> <p>Snowball sampling</p>	<p>One participant was retired from nursing.</p>	<p>Analysis followed Husserl and Gorgio's method.</p>	<p>2. Dissatisfaction with responses: administrative and law enforcement</p> <p>Most nurses reported dissatisfaction with the way that their management teams responded to their experience of violence at work. Law enforcement was experienced to be unhelpful to the nurses who tried to pursue charges.</p> <p>3. Helping others</p> <p>Nurses experienced their immediate teams as being supportive: that they operated as a family, with everyone helping each other.</p> <p>4. Surprise/disbelief</p> <p>Nurses predominantly experienced violence perpetrated against them to be a surprise and that they could not believe it had happened to them.</p>
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1.3.2. Meta-synthesis

Four meta-themes (*Violence in the ED*, *“Nobody cares, nothing changes”*, *Peers and perpetrators* and *“On the front line with only... malfunctioning weapons”*) were identified and mapped onto Bronfenbrenner’s (1979) ecological model. Meta-themes with respective sub-themes are depicted in Table 6.

Table 6. Meta-themes and sub-themes

Bronfenbrenner’s model	Meta-themes	Subthemes
Macro-system	1. Violence in the ED	Violence and aggression faced by nurses in the ED Social complacency and the law
Exo-system	2. “Nobody cares, nothing changes”	The media: Nurses lynched Management: “see my bruising” Environmental factors Patient implications: “don’t really care if they live or die”
Meso-system	3. Peers and perpetrators	Peers: “we are family” The perpetrator
Micro-system	4. “On the front line with only... malfunctioning weapons”	I am a nurse: it’s “in our work contract” I am a person with “lingering trauma” My future

Applying Bronfenbrenner’s (1979) ecological model to the current meta-ethnography illustrated the pervasive nature of violence and aggression as it is experienced by nurses in the ED. Tolerance, perpetuation and reinforcement of violence directed toward nurses in the ED is evident across the four levels of macro-, exo-, meso- and micro-systems.

The frequency of sub-theme occurrence by individual paper reviewed in the current meta-ethnography is illustrated by Table 7.

Table 7. Frequency of each sub-theme by original papers

Meta-theme	Violence in the ED		Nobody cares, nothing changes				Peers and perpetrators		“on the front line with only... malfunctioning weapons”		
	Sub-theme	Violence and aggression faced by nurses in the ED	Social complacency and the law	The media: Nurses lynched	Management: “see my bruising”	Environmental factors	Patient implications: “don’t really care if they live or die”	Peers: “We are family”	The perpetrator	I am a nurse: it’s “in our work contract”	I am a person with “lingering trauma”
England et al. (2014)	✓	✓			✓	✓		✓	✓		✓
Christie (2015)		✓		✓			✓		✓		✓
Gillespie et al. (2013)	✓				✓			✓			✓
Han et al. (2017)		✓				✓			✓	✓	
Hassankhani et al. (2018)								✓		✓	
Hislop et al. (2003)		✓				✓	✓	✓	✓	✓	
Howerton Child & Sussman (2017)				✓	✓	✓	✓		✓	✓	✓
Hyland et al. (2016)					✓						✓
Lau et al. (2012)	✓	✓			✓			✓	✓		
Luck et al. (2012)	✓	✓						✓	✓	✓	
Pich et al. (2011)	✓				✓	✓		✓	✓		
Pich et al. (2013)	✓	✓	✓		✓	✓		✓	✓	✓	✓
Ramacciati et al. (2015)	✓	✓					✓		✓	✓	✓
Ramacciati et al. (2018)	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
Tan et al. (2015)	✓	✓		✓		✓	✓	✓			✓
Wolf et al. (2014)		✓		✓	✓		✓		✓	✓	
Wright-Brown et al. (2016)		✓	✓	✓			✓		✓		

Each meta-theme (and respective subthemes) is discussed in detail below. For further quotations evidencing each sub-theme, see Appendix G.

1.3.3. Meta-theme 1: Violence in the ED

The meta-theme of **Violence in the ED** conceptualises the wider world of the nurse within the macro-system level of Bronfenbrenner's (1979) model. Nurses experience the world constructed around them, with little direct influence over this at a personal level. The macro-system influences not only the nurse at the heart of the system, but others who interact with the system.

Two sub-themes were identified: *Violence and aggression faced by nurses in the ED* and *Social complacency and the law*.

1.3.3.1. Violence and aggression faced by nurses in the ED

This subtheme highlights the challenge faced by ED nurses in making sense of their experiences and establishing a personal and professional narrative of what it means to be a (frequent) victim of violence and aggression.

"it's very frequent. Not carefully studied or understood, not even by the nursing and medical staff of the Accident and Emergency department"

(Ramacciati et al., 2018, p.23)

Aggression was typically conceptualised by nurses across studies to be behaviour that was closely associated with violence but did not involve physical contact.

“Aggression I would define... as where somebody would use language or body language that you could deem to be threatening or that may have a hint of violence behind it without being physically violent” (Angland et al., 2014, p.136)

Aggression included threats to cause harm (including threats to kill) and swearing.

“I’m going to follow you to your car... find out where you live, I’m going to kill you. I’m going to hurt your family...” (Pich et al., 2013, p.159)

Predominantly, violence was defined as physical acts. These were extensive and varied in nature as highlighted below:

“biting, choking, grabbing, kicking, pinching, pulling hair, punching, scratching, shoving, slapping, spitting, throwing objects or body fluids, and brandishing a weapon such as a firearm, knife or sharp object” (Gillespie et al., 2013, p.4)

Nurses recognised the inherent vulnerability of their workplace with respect to a perpetrator’s access to, actual and opportunistic, weapons. Threats to life were experienced as being a genuine possibility. The sheer scale of potential weapons from used ‘sharps’ (such as needles), to knives and poles for fluids bags did not go unnoticed.

1.3.3.2. *Social complacency and the law*

Despite known criminal behaviour (for example assault) being perpetrated, in the world of the nurse, repercussions do not align with the 'real' world: they are not a victim. The reviewed papers suggest it is not considered necessary to pursue prosecution – if anything, doing so is a waste of taxpayer's money and police time.

“I was later called by the DA [district attorney], who wanted nothing to do with the case, since he thought it was a waste of taxpayer dollars, as the man would just cop a plea, get his hands slapped and nothing further would happen” (Wolf et al., 2014, p.307)

A more extreme example illustrates how nurses in the ED are led to believe their worth is lower than the material features of their workplace when considering engaging the judicial system.

“If a client damages something belonging to the hospital, like a door, the hospital takes that person to law. If the client hits me and I want to take him to law over this, I have to do it by myself. And this is one of those things that leaves a bitter taste: it means that I am not as important as that door” (Ramacciati et al., 2015, p.277)

Nurses spoke of being deterred from pursuing charges and being left feeling isolated and unsupported after deciding to prosecute. A judicial system which allows perpetrators to go unpunished perhaps reflects a wider societal issue - nurses fundamentally are not valued.

“As a profession, nursing is not thought to play an important role in society, as it is still considered subordinate, and filled with people who follow orders”
(Ramacciati et al., 2018, p.24)

The perpetuation of this belief has the potential to legitimatise violence toward nurses. If nurses are perceived as ‘lesser humans’, then the violation of their rights is seemingly more tolerable to perpetrators. This may explain why people (uncharacteristically) behave violently toward nurses in the ED:

“I’m really sorry I was like that... it wasn’t personal... I wouldn’t normally be like that” (Pich et al., 2013, p.160)

1.3.4. Meta-theme 2: “Nobody cares, nothing changes”

The meta-theme of **“Nobody cares, nothing changes”** illustrates the exo-system level of the ecological model. It explores the way in which structures and systems directly around the nurse influence their experience of violence. This can be systems in close physical proximity to the nurse (for example their working environment, and managerial support), or more distal (including the media portrayal of nurses).

Four sub-themes were identified: *The media: nurses lynched*, *Management: “see my bruising”*, *Environmental factors* and *Patient implications: “Don’t really care if they live or die”*.

1.3.4.1. *The media: nurses lynched*

The media were identified as a potential contributor to negative attitudes of nurses in three of the included studies (Pich et al., 2013; Ramacciati et al., 2018; Wright-Brown et al., 2016).

“The civil servant has been lynched publicly in the press in the past few years. Tabloid journalism has wrongly described medical malpractice as a scandal which has tended to increase violence in the hospital setting” (Ramacciati et al., 2018, p.24)

Potential perpetrators may perceive nurses to be legitimate targets through the media exposing ‘nurse failings’ – reporting (seemingly exclusively) scandals and malpractice within the profession. With nurses positioned as the face of the healthcare system, the perpetrator may be motivated to act in defence of failed patients, or to avoid being the victim of malpractice themselves. Consequently, nurses experience the media as perpetuating the stereotype of their minimal value and as a contributor to their vulnerability in the workplace.

The perceived risk the media poses is also echoed by management responses to violence. Nurses spoke of being actively approached by their seniors, after incidents of violence, with the sole intention of preventing the nurse engaging with the media. This may be experienced by nurses to be indicative of their value being secondary to the maintenance of a reputable service.

“That was the first phone call we got... don’t talk to reporters” (Wright-Brown et al., 2016 p.195)

1.3.4.2. Management: *“see my bruising”*

Nurses experienced their managers as less concerned with their well-being, and more concerned with patient satisfaction. Nurses perceived the management as detached: unaware of the world within the ED. They called for the management to live the reality of the ED alongside them, not shy away from it.

“I think it would open their eyes to what we really deal with, but they’re safe in their offices” (Christie, 2015, p. 34)

There was an appreciation that management are presented with an impossible task of having a reputable service and a safe workforce. These two goals can be disparate in nature, which results in one being prioritised over the other. For the nurses, it is perceived that predominantly the patients are the priority.

“Management tries to help... They want to make everyone happy, which is impossible” (Howerton Child & Sussman, 2017, p. 549)

Nurses were disillusioned about whether their well-being would ever be prioritised. They described a desire to connect with management on a person-to-person level: to step aside from professional roles and confront superiors with the intimate reality of nursing in the ED.

“I wanted them to see my face and see my bruising...” (Wolf et al., 2014, p.307)

Nurses may be particularly motivated to seek this connection when, after seeking managerial support previously, nothing has changed, and they are targeted once again. Where nurses have experienced multiple incidents of aggression and violence, it is perhaps expected that they are disappointed with (the lack of) managerial action.

1.3.4.3. Environmental factors

Nurses recognised the ED was not conducive to positive engagement with patients. Nurses described holding a level of empathy for the patient’s experience in that environment, without condoning violent behaviour. It was appreciated that everyone entering the ED is exposed to unpleasant conditions. Nurses across studies variably acknowledged the (often limited) emotional and behavioural thresholds of patients and visitors given the typical circumstances leading to a patient accessing the ED.

“there were so many patients on the corridor the heat and noise was cruel... you just knew someone was about to fly off the handle” (Angland et al., 2014, p. 136)

There was also consensus that the set-up of the ED department, with long waiting times and high rates of patient access, increased the potential for violence and aggression. Frequently, the lack of security measures, and the free access to the department leave nurses especially vulnerable.

“the department is not secure – people continue to come and go freely”

(Hyland et al., 2016, p.146).

This was noted to be further exacerbated by the relational experience of the waiting room which was described as an audience for aggressors to perform in front of. This may contribute to an unhelpful and hostile ‘us and them’ mentality between those awaiting treatment, and those attempting to provide it.

“I think the patient realises that they have an audience and play up to it”

(Hislop et al., 2003, p.8)

This audience effect poses additional challenges. Nurses noted that, in order to keep everyone safe, perpetrators were often fast-tracked through the department. This caused discomfort with nurses – they do not want to reinforce and condone such behaviour and yet this maintains safety. Nurses were concerned that this fast-tracking demonstrated to others in the waiting area that behaving aggressively or violently accelerates the treatment process, thus leaving nurses additionally vulnerable.

“It’s like Chinese whispers... the domino effect” (Pich et al., 2013, p.159)

Overall, the nurses experience their environment as threatening and providing inadequate protection:

“I feel less safe here than I did in the military” (Pich et al., 2013, p.160)

1.3.4.4. *Patient implications: “Don’t really care if they live or die”*

Patient- and visitor- initiated violence has implications for patient care. This was reflected in nurses negating professional responsibilities, for example choosing to by-pass stages of intervention and, instead, doing whatever they could to get the patient moved from the ED.

“I don’t really care if they live or die – I just want to get them out of there.”

(Han et al., 2017, p.433)

Nurses acknowledged that their ability to perform tasks to the appropriate standard was negatively impacted when they were operating in a state of threat. This reflects the idea that violence is often not a discrete incident: the consequences are far-reaching, often with implications for those without any direct involvement in the initial incident. The traumatised nurse cannot focus on the task at hand for fear of a re-occurrence:

“your attention risks being distracted from the patient. Especially during triage when you are constantly interrupted while assigning priority codes”

(Ramacciati et al., 2018, p.26)

Depleted nurse confidence following violence consequently impacts on the patient’s privacy. Nurses who feel disempowered and vulnerable are more likely to seek a chaperone (such as security staff) when providing triage and treatment. In such

circumstances, not only is the patient in the vulnerable position of telling their story to the nurse, but they are also sharing intimate details to other, potentially non-healthcare, professional(s).

“At least... for a while, I’ll not go outside (waiting room) to talk to a patient without the company of security” (Lau et al., 2012, p.128)

This theme highlights a vicious cycle between nurse behaviour resulting from patient-initiated violence and the perpetuation of the notion that nurses provide substandard care (as reported by the media).

1.3.5. Meta-theme 3: Peers and perpetrators

The meta-theme of **Peers and perpetrators** explores the immediate relational world of the nurse within the meso-system of the ecological model. At this level, nurses experience direct and reciprocal engagement with others in their world. In this case: their nursing peers, and the perpetrators of violence against them.

Two sub-themes have been identified: *Peers: “we are family”* and *The perpetrator*.

1.3.5.1. Peers: “We are family”

Nurses benefitted from the support of peers with lived experience of violence in the ED. The sense that nurses described their immediate colleagues as *“We are family”* (Wright-Brown et al., 2016, p.195) suggests inter-related responsibilities to care for,

and protect, each other. Such lifelines, connecting with those who truly understand, are invaluable.

“without that support from your colleagues, you wouldn’t survive” (Hislop et al., 2003, p.9)

Perhaps recognisable to many families, there were times when the biggest source of support became an equally significant source of frustration. Nurses acknowledged that certain colleagues had a talent for exacerbating situations, reflecting that nurse behaviour can be a trigger for violence (albeit, not warranting this).

“... she was getting the patient so fired up, and it didn’t have to go that way ... she’s already starting the relationship off in the wrong way...” (Howerton Child & Sussman, 2017, p.548)

It is likely challenging for nurses to consolidate the internal conflict that your peer can both protect you and contribute to your vulnerability. In life-and-death environments, as ED inherently is, there is comfort in knowing that your colleagues are there to guide and support you, and to intervene appropriately.

“As soon as we hear raised voices from the Triage area, somebody automatically leaves the surgery and goes to give support to the colleague out there” (Ramacciati et al., 2015, p.277)

Inconsistent peer support may add an additional layer of anxiety for nurses in the ED.

1.3.5.2. *The perpetrator*

Perpetrators are described with commonalities including people who have a mental health condition, those with a history of violence and/ or police involvement, and “frequent flyers” (Gillespie et al., 2013, p.6).

“People with mental health issues can escalate and make a big scene very quickly” (Pich et al., 2011, p.15)

Nurses perceived intoxication to be a risk factor for violence due to the potential perpetrator’s consequent impulsivity and lack of control over their urges and behaviour.

“It’s the stranger, the person you don’t know, with alcohol on board – they are the ones to watch and be afraid of. You just don’t know how they are going to behave because they can just turn around and let loose on you” (Hislop et al., 2003, p.10)

In a climate of stretched resources across healthcare, nurses recognised increased pressure on services in the ED which, in part, was hypothesised to be as a result of patients inappropriately accessing the ED without being acutely ill. Nurses experienced violence as even less tolerable when perpetrators were perceived to access the ED unnecessarily or to demand their care is prioritised despite no evident critical care needs.

“Like take a look at yourself, you know you’re not really that sick. You’re here with a sore toe, there’s people dying next door, there’s kids that can’t breathe...” (Luck et al., 2008, p.1076)

1.3.6. Meta-theme 4: “On the front line with only... malfunctioning weapons”

The meta-theme of **“On the front line with only... malfunctioning weapons”** conceptualises the personal world of the nurse: the micro-system of the ecological model. At the micro-system level, the individual’s core identity is consolidated. They are a multi-faceted professional, with a lived history, a current experience, and hopes for the future.

Three sub-themes are described: *I am a nurse: it’s “in our work contract”*, *I am a person with “lingering trauma”* and *My future*.

1.3.6.1. I am a nurse: it’s “in our work contract”

The priority for a nurse attending to a patient in the ED is stabilising their physical health. This priority can be at the detriment of nurse’s well-being as they do not always make adequate risk assessments prior to engaging with the patient.

“The nurse did not perceive the patient as a threat because she was concerned about his physical condition” (Lau et al., 2012, p.128)

There was conflict about the prospect of violence and aggression being “*part of the job*” (Pich et al., 2013, p.159). Although this sentiment was echoed across several of the included studies, for some, experience of violence represented an initiation into nursing in the ED.

“Everyone has been telling me for two years that I’d have to expect violence in A&E and then I was hit and felt well now I’m initiated” (Hislop et al., 2003, p.10)

The perception that violence was expected was experienced, by some, as somewhat comforting. This seemingly lessened the emotional burden of experiencing WPV, perhaps through a process of de-personalisation: it is experienced as happening to the nurse as part of the respective job role, distinct from the rest of the person.

“I’m not affected that much, because I think it [aggression] is normal inside ED, and people come in with these kinds of conditions” (Tan et al., 2015, p.309)

However, there is not unanimous consensus regarding nurses being almost obliged to experience violence in the ED.

“I continue to hear other nurses say violence is ‘part of the job’ which I find maddening” (Wolf et al., 2014, p.308)

This may be reflective of an underlying recognition that the 'tolerance' for violence observed in nurses may actively contribute to perpetuating the risk. In turn, this validates the complacency of the other levels of the ecological system when broaching or enforcing meaningful change.

1.3.6.2. *I am a person with "lingering trauma"*

It is perhaps unsurprising that nurses experience both psychological and physical trauma because of violence and aggression directed toward them. Nurses experience threats to their lives, and the lives of others they care about, and are intimidated by those they are trying to care for.

"His voice was in my ear for several months. I was extremely scared."

(Hassankhani et al., 2018, p.22)

The myriad of post-traumatic symptoms reported across the included papers indicate that this is a frequent post-incident consequence for nurses. Nurses do not experience trauma as a single, discrete event. It is typical for nurses to return to work following the trauma either immediately (i.e. continuing their shift) or in the future without time spent containing or validating their experience. Nurses also recognised that it was unlikely that protective measures would be instated as a result of their traumatic experience. The re-traumatisation of nurses is reflected through the description of victimhood as:

"An on-going nightmare" (Han et al., 2017, p.433)

In addition, nurses are unprepared for how psychological trauma might become evident in their lives after the event. For example:

“I managed to handle these situations as they occurred but would become diaphoretic, shaky and feel palpitations afterward” (Wolf et al., 2014, p.307)

The physical trauma experienced by nurses can also be variable, with long-standing consequences for the nurse. This includes “a broken nose... wrist injury; ligament damage to thumb; scratches; bruises; and injury to finger” (Pich et al., 2013, p.159).

“I ended up tearing cartilage in my left knee, ended up having surgery. I work with chronic pain and will need a knee replacement... I limped for months but still worked full time” (Wolf et al., 2014, p.308)

Nurses are left with a victim identity, which can be difficult to consolidate when they are used to being “*superman*” (Wolf et al., 2014, p.307).

1.3.6.3. *My future*

Nurses expressed concerns for their own well-being, and that of other nurses, and had formulated plans for enhancing safety. This included the implementation and maintenance of security measures such as weapons detectors, panic alarms and an active security presence.

Nurses perceived their reality to be one that featured on-going violence and aggression perpetrated by patients and visitors, with some citing potential for lethal consequences.

“nurses are going to be killed” (Pich et al., 2013, p.159)

Ultimately, nurses expressed a need to take control for their own protection given the (actual and perceived) lack of managerial, corporate, and societal response to their continued endangerment. At this juncture, the only option is to ‘fight fire with fire’:

“We need machine-guns!” (Ramacciati et al., 2018, p.26)

This illustrates the dominant war-zone metaphor which pervades the ecological system of the nurse. Nurses experience their workplace as a battle zone for which they are under-resourced.

“you’re on the front line with only obsolete or malfunctioning weapons. It’s not a nice way to work” (Ramacciati et al., 2018, p.26)

Nurses were also disheartened by the lack of meaningful change when their recommendations for safety measures are made.

“we have made some suggestions for improvements... but the machinery works so very, very slowly and that makes people angry” (Ramacciati et al., 2015, p.277)

Despite advocating for deterrents and proactive management, nurses remain hopeless and helpless at the centre of it all.

1.4. DISCUSSION

Nurses' lived experiences of violence and aggression in the ED is a multi-faceted issue spanning all levels of the ecological model (Bronfenbrenner, 1979). In contrast to the model presented by Di Martino (2002), the current model of nurses' experiences of violence in the ED additionally highlights the relational (meso-system) and personal (micro-system) aspects of violence and aggression.

At the macro-level, nurses are subjected to a variety of violent and aggressive behaviours at a frequent rate. Consistent with previous literature (Ferns et al., 2005) nurses experience the wider culture that they operate in as reinforcing their position as subordinate humans, not deserving of victimhood. Despite criminal actions being committed, the assailant invariably goes unpunished.

The exo-system identified how the immediate environment of the nurse perpetuates violence perpetrated against them. Nurses perceived management to be unaware of the reality of violence in the ED and more concerned with the reputation of the hospital than the safety of staff. Additionally, nurses saw themselves as subordinate with management placating rather than punishing perpetrators. It also emerged that nurses are caught in a vicious cycle: they are portrayed negatively by the media, which is believed to underpin the legitimisation of them as a target for violence. When the nurse is subsequently assaulted, they may be less willing or able to

provide their typical standard of care both to aggressors and (unintentionally) other patients. This serves to evidence the media's assertion that nurses deliver substandard care. This relationship has not previously been identified in the literature informing this review. It has implications both for the protection of nurses in the ED, and the quality of care patients can expect to receive in that environment. Moreover, it highlights a social responsibility of institutions (such as media outlets) to be active contributors in the reduction of violence perpetrated against nurses.

At the meso-system level, nurses experience violence relationally. Nurses subjected to violence are engaged in challenging relationships with the perpetrators: the typical power dynamics of nurse and patient are reversed. Certain presenting complaints and comorbidities were associated with increased likelihood of the patient behaving aggressively or violently particularly intoxication and mental health difficulties which perhaps contributes to the sense of inevitability of violence in the ED. Nurses also recognised that they are less tolerant of those who access the service inappropriately which is consistent with previous literature (Dal Pai & Lautert, 2011, as cited in Midori Sakai et al., 2016). The meso-system level illustrated how nurses have a secondary conflicting relationship: this time with their peers. Other nurses were identified as being an important provider of post-incident support, whilst also having the potential to increase vulnerability of nurses by exacerbating challenging situations. This, consistent with a previous review (Ashton et al., 2018), highlights the importance of nurses being aware of their own behaviour in order to proactively manage potentially violent situations and in maintaining safe and therapeutic relationships.

This review has illustrated the potential impact of violence not only on well-being of the individual in their identity as a nurse, but also as a human being at the micro-level. This is supported by previous literature highlighting one of the consequences of experiencing violence was nurses' intention-to-leave (Farrell & Bobrowski, 2003). This meta-ethnography extends the current literature by drawing attention to the nurse as a person: their profession constitutes only part of their identity. The experience and consequences of trauma is not localised to the workplace: for some, it has a constant presence.

1.4.1. Clinical implications and recommendations

The myriad of factors precipitating and maintaining violence in the ED indicate that meaningful change would likely require concurrent targeted responses across each level of the ecological model.

Interventions to date have focused on managing violence as it occurs, including the variable implementation, and enforcement, of zero-tolerance policies. Despite the current interventions, there continues to be violence and aggression perpetrated against nurses in the ED. Perhaps these interventions serve only to reinforce the position that it is the nurse's responsibility to manage violence, rather than the perpetrator's responsibility to not be violent. It is appreciated that deterrents are favoured by the nurses themselves, however, these are only effective if acted upon consistently and meaningfully at the macro-system level (i.e. legal consequences imposed as standard not exception). In addition, this meta-ethnography highlights that nurses repeatedly call for changes to their physical environment to increase their

sense of safety, for example having security presence, personal alarms, and appropriate staff-to-patient provision.

Proactive management strategies alongside the consequences and deterrents already in place in EDs may be especially beneficial. This could include campaigns for reducing violence which focus on fostering favourable attitudes toward the nursing profession (exo-system level). Educating patients on the role of EDs and expectations for treatment in that environment (meso-system) may also be beneficial. Applying this to the ecological model (Bronfenbrenner, 1979), the behaviour of one part of the system will have ripple effects in its other parts.

Reducing unnecessary admissions to EDs through educational programmes would result in reduced workload stress for nurses. With a lower throughput of patients, nurses can work more efficiently which motivates a positive reputation with the public: breaking the vicious cycle highlighted by the current meta-ethnography.

Training in violence and aggression management which focuses on de-escalation skills and interpersonal effectiveness may support a reduction in nurse-related factors recognised to exacerbate aggressive or violent situations. There is a need for nurses to recognise their own behaviour as potential triggers for violence and adjust this accordingly.

With the increasing awareness of trauma-informed care, it is interesting to identify that nurses are expected to work in (re-)traumatising environments both prior to, and after, experiencing WPV. The facilitation of clinical supervision, which is reflective in nature, may offer nurses the opportunity to explore their emotional responses and

collaborate with supervisors to overcome barriers to being effective in their professional role (Knight, 2018). This should include trauma-informed principles embedded within the supervisory process: safety, trust, choice, collaboration, and empowerment (Berger & Quiros, 2016). Additionally, helping individuals to identify positives in a traumatic experience (for example having a deeper connection with what truly matters) supports a move toward a position of post-traumatic growth including increased empathy (Knight, 2018). This type of supervision may be particularly important given the reduction in empathy that nurses in the current review have reported.

Trauma-informed care also advocates for individuals to take practical steps to manage their own self-care including striking a healthy work-life balance (Knight, 2018). This positions the nurse as an active participant in the change of the system in which they exist.

1.4.2. Limitations

The limitations of this meta-ethnography include the fact that included studies report experiences of nurses who work in different healthcare systems. It is recognised that there may be different expectations of healthcare provided in these respective settings. For example, in fee-paying circumstances, it is often expected that care is doctor-led rather than nurse-led – perpetuating a belief that ‘better’ care is provided by physicians (Yuwanich et al., 2017).

By including a global literature, different cultures are also being represented. This may be somewhat problematic based on the assumption that violence is a culturally

bound concept (International Labor Office et al., 2002 as cited in Najafi et al., 2018) and thus what is considered violence in one study may not be in another.

It is acknowledged that non-English language papers were excluded from the current review which introduced a language bias (Butler et al., 2016). This was unavoidable due to time and cost implications of translation.

1.4.3. Future research

Future research would benefit from systematically reviewing attempts to reduce violence and aggression perpetrated against the nurses in ED. From the literature reviewed in the current meta-ethnography, interventions include additional security measures (such as personal alarms or security presence), efforts to create more positive outlook of nursing as a profession, and training in the management of violence and aggression. Each of these interventions has been perceived by nurses with lived experience as having a benefit to enhancing their safety at work. As such, empirically validating these measures should be prioritised to ensure the interventions that services develop are efficacious.

Furthermore, research indicates that violence in the ED is a complex picture. There may be value in exploring the experiences and narratives of other parts of the ecological model for example perpetrators of violence against nurses and the managers of nurses who experience WPV. This would contribute to a more holistic understanding of the interplay of factors related to violence in the ED.

The apparent paucity of research in this field over the past eighteen years may be understood as the rhetoric of evidence-based practice not translating into active engagement in research by nurse-researchers (Ferns et al., 2006). An understandable concern is that, without the drive from nurses to pursue research in their clinical environments, research will be conducted by other professions or not at all (Ferns et al., 2006). This potentially leads to either stagnant evidence bases, or literature which is not truly representative of the nurse experience, consequently having little or no meaningful practical application. As such, it would be appropriate for further research to be conducted by nurses, in geographically discrete areas. This would contribute to more robust evidence-bases of nurses' realities in experiencing violence in the ED with practical applications for the system they work within (e.g. privatised or free at the point of access) and the nursing community they represent.

1.4.4. Conclusion

Nurses continue to be exposed (repeatedly) to violence in the ED and existing interventions demonstrate limited efficacy. This meta-ethnography provides further clarity on nurses' experiences of violence and aggression in the ED, including a novel finding concerning the role of the media in perpetuating violence directed toward nurses in the ED. Violence and aggression is pervasive and is being perpetuated and maintained across the nested levels of the ecological system. Future interventions should target all levels of the model to meaningfully reduce violence and aggression directed toward nurses in the ED. Adopting a proactive and trauma-informed approach focused on fostering positive attitudes to the nursing profession, facilitating effective post-incident support, and enhancing relationships

across the system has the potential to reduce violence and aggression and improve well-being within the profession: a move from hopeless to hopeful.

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2.0. CHAPTER TWO

“We should know if they’re being abused but we don’t”

Student mental health nurses’ perceptions of control and restraint

This chapter has been prepared for submission to the *Journal of Psychiatric and Mental Health Nursing* (see Appendix H for the journal’s author instructions)

Word count: 8442 (exclusive of tables, figures, footnotes, and references)

ABSTRACT

Introduction: Control and restraint (C&R) are last resort interventions, used to manage challenging situations (including violence) in acute and secure mental health settings and known to be (re-)traumatising for all involved. Currently in the United Kingdom (UK), student mental health nurses (SMHNs) are trained in breakaway techniques, but not in the use of C&R.

Aim/ Question: To understand SMHNs perceptions of C&R, in the context of no active experience.

Method: A qualitative study of 15 semi-structured interviews conducted with SMHNs.

Results: Following applied thematic analysis, three codebooks were revealed: “context”, “moral dilemma” and “the aftermath”.

Discussion: SMHNs perceive C&R to be an unpleasant, yet inevitable, feature of their future career and an undertaking they are under-prepared for.

Implications for practice: SMHNs would benefit from further training in C&R to enhance clinical competence and confidence; and from clinical supervision building emotional resilience to proactively manage the demands of C&R in practice.

Abstract word count: 151 words

Key words: mental health nursing, student, nurse training, control, restraint, applied thematic analysis, qualitative interviews

2.1. INTRODUCTION

2.1.1. *Background*

The National Institute for Health and Care Excellence (NICE, 2015) reported that in 2013-14, almost 70,000 assaults were recorded against healthcare staff; 69% of those occurred in mental health (MH) or learning disability (LD) settings.

Management of violence and aggression in these contexts is understood to be challenging (Department of Health [DOH], 2014a) and may involve the use of control and restraint (C&R) as a last resort. Such interventions are known to be potentially (re)traumatising for all involved (Bonner et al., 2002). Proactive management of violence and aggression is encouraged; however, at times, these are insufficient in managing the risk(s) presented (DOH, 2014b).

In their most recent guidance regarding the management of violence and aggression in MH settings, NICE (2015) highlights the importance of staff training in C&R. It emphasises the potential for staff attitudes and behaviours to foster a culture which exacerbates the potential for aggressive or violent behaviour initiated by the service user (SU). The guidelines outline recommended components of training in C&R, and the Mental Health Units (Use of Force) Act (2018) highlights the responsibilities of individuals in its use within United Kingdom (UK)-based services⁴. The Restraint Reduction Network ([RRN], Ridley & Leitch, 2020) has recently published training

⁴ Programmes used in the UK include MAPA (Management of Actual or Potential Aggression) and PMVA (Prevention and Management of Violence and Aggression). The exact content of each course and respective skills varies slightly, but typically includes modules in de-escalation, breakaway and graded levels of physical intervention including floor (supine and prone) restraints, seated restraints and standing safeholds.

standards (adopted as compliance markers by the Care Quality Commission [CQC] in April 2020) in response to criticism that training in C&R is not standardised or accredited.

2.1.2. Use of terminology

In the current study, *student mental health nurse* (SMHN) refers to those currently enrolled in a programme of education for mental health nursing.

This study defines *control* as the measures which limit personal autonomy of the SU including detention under the Mental Health Act (MHA, 1983). Secure MH wards (including acute wards and Psychiatric Intensive Care Units [PICUs]) are wards to which SUs are admitted either under the MHA (MHA; 1983), or informally, for a period of stabilisation either before transfer to a more secure environment, or discharge to the community. The varying degrees of controls exerted over an individual detained in a secure unit are outlined by Collins et al. (2001, 2003) in the Security Needs Assessment Profile (SNAP)⁵. Only those admitted to such wards under section of the MHA (1983) may be subjected to restraint procedures.

Restraint can be sub-divided into three categories: physical, chemical, and environmental. Physical restraint involves physically hindering an individual's movement through direct contact with their body (Bonner et al., 2002; Bauer & Weust, 2017). Chemical restraint concerns the administration of medication either orally or via intramuscular injection (IMI) against the will of the individual (Currier,

⁵ SNAP is a structured framework is used to support the decision-making process for assigning the appropriate level of security for psychiatric inpatient wards and SUs accessing these wards.

2003). Environmental restraint includes seclusion whereby an individual is confined to a low stimulus room, with no means of leaving of their own volition (Kinner et al., 2017).

2.1.3. MH nurse training: Current practice in the UK

SMHNs in the UK are currently trained in breakaway techniques which are designed to remove the potential victim from a threatening situation, without apprehending the aggressor (Lamont et al., 2012). Over the course of their training, SMHNs may attend placements in settings where C&R are used (for example acute or secure MH units) but they are not trained to engage in this. A report by the Royal College of Nursing ([RCN]; 2019) identified that student nurses are amongst the most vulnerable cohorts within nursing in terms of victimhood from physical or verbal abuse. Their vulnerability of not being able to engage in C&R has also been highlighted by previous research identifying sources of stress for SMHNs (Galvin et al., 2015).

It is recognised that it would be unethical to orchestrate opportunities for SMHNs to actively participate in restraint, however, Wright et al., (2005) highlighted the importance of equipping SMHNs with the skills needed to recognise and manage violent and aggressive situations. Leaving the responsibility of C&R training to post-qualification, or to observations of qualified staff during placements is potentially dangerous. Erdil and Korkmaz (2009) suggested that, due to several factors (including poor staffing ratios and stressful working conditions) qualified nurses become less reputable role models: potentially demonstrating abusive practice to SMHNs who may be naïve to this.

2.1.4. Previous research

Previous literature has focused on perceptions of qualified staff and other key stakeholders regarding the use of C&R (Bigwood & Crowe, 2008; De Benedictis, et al., 2011; Kinner et al., 2017; Vedana et al., 2018). This has resulted in a more robust understanding of factors influencing the decision-making process and highlighted the relationship between experience in the nursing role and the intrapersonal conflict, and psychological impact, of C&R (Riahi et al., 2016).

Research interests have recently shifted to examine C&R from the SU perspective. This advancement is aligned with policy and professional drivers including from the Department of Health (DOH; 2014b). Its *Positive and Proactive Care: Reducing the Need for Restrictive Interventions* document emphasises the importance of stakeholder involvement when considering restrictive practice including C&R (DOH, 2014).

Bonner et al., (2002) investigated the experience of both staff and SUs in relation to the use of restraint. Key findings include the longstanding emotional distress of C&R (exceeding the physical process), and the potential for staff behaviour to enhance or impede the therapeutic relationship following restraint.

Research investigating SMHNs' attitudes and perceptions is scarce and, to date, has employed quantitative design. Bowers et al., (2007) reported that students who most positively endorsed working with individuals with a diagnosis of personality disorder were also the students most likely to endorse containment measures with this SU population. The authors acknowledged this research was limited in terms of

establishing a holistic understanding of SMHNs' perceptions of C&R and advocated qualitative exploration.

2.1.5. Rationale and Research Question

C&R in psychiatric care is poorly understood both in terms of SU and staff perceptions and experience (Kinner et al., 2017). Understanding the SMHNs' perceptions of C&R has implications for nurse training and clinical practice. It is well documented that C&R elicits an internal conflict (Vedana et al., 2018) for staff members trying to integrate their identity as caring professionals providing safety and containment (Lach et al., 2016) whilst re-traumatising the SU (Sweeney et al., 2016). Understanding the perceptions of SMHNs prior to their lived experience may help to inform appropriate support systems for novice staff members in relation to training, supervision, and reflective practice. Given high rates of intention to leave the profession, especially during the initial post-qualification years (Yeh & Yu, 2009), the current research may indicate potential avenues for enhancing the preparedness of novice nurses.

The rationale for the current study is threefold. Firstly, there is a paucity of research concerning the perceptions of SMHNs in relation to C&R. Secondly, previous research with this population has adopted a quantitative approach and would benefit from a qualitative exploration (Bowers et al., 2007). Thirdly, by understanding SMHNs' perceptions of the impact of engagement in C&R on their well-being, education providers and MH service-providers may be better placed to support SMHNs proactively. That is, specifically targeting this population prior to their first

experience of C&R, to prepare them emotionally and procedurally for this undertaking.

The research question is, therefore, *what are SMHNs' perceptions of control and restraint?*

2.2. METHODS

2.2.1. Research Design

This study employed a qualitative design with applied thematic analysis. This approach involves eliciting perceptions, attitudes, and beliefs of a specific cohort, concerning a given subject (Braun & Clarke, 2006). For the purposes of the current study, individual interviews were used to generate data. This enabled the researcher to encourage participants to elaborate on their responses and reduced the likelihood that the participant's contributions were influenced by the presence of others (Rose et al., 2013).

2.2.2. Participants

2.2.2.1. Recruitment

The study employed a non-probability snowball sampling design (Etikan et al., 2015). Recruitment posters were distributed by universities across England and South Wales after being directly contacted by the researcher. The poster was also shared via social media platforms (Twitter and Facebook). Additionally, participants shared their awareness of the current research with their peers, furthering the snowballing recruitment.

In total, 33 potential participants expressed interest in the study and were provided with the participant information sheet (PIS; Appendix I) via email. Subsequently, 18 participants were either not eligible or did not make further contact with the researcher. Recruitment ceased at the point of data saturation.

2.2.2.2. Eligibility criteria

Given this study used applied thematic analysis, the inclusion criteria (Table 8) focused on generating the perspective of a specific population: SMHNs.

Table 8. Inclusion and exclusion criteria

Criteria	Inclusion	Exclusion
Student Mental Health Nurse	Student Mental Health Nurses currently enrolled in training, any year of study	Student Nurses of other sub-divisions (e.g. Student Learning Disabilities Nurse)
Experience of C&R	No experience during, or prior to, nurse training Witnessing but not actively participating in C&R	Active participant in C&R in any role (including as a healthcare assistant)
Participant verbal language	English speaking	Other language British (or other) Sign Language
Geographical region	United Kingdom (UK)	Rest of the World

SMHNs, rather than other student nursing populations, were included as they are most likely (alongside LD Nursing Student counterparts) to be in settings where C&R procedures are implemented (Marangos-Frost & Wells, 2000).

The current study focused on SMHNs' perceptions of C&R having not actively engaged in this. Previous involvement, even in an alternative role (e.g. as a healthcare assistant [HCA]), precluded participation.

The decision to include UK-only participants was driven by the on-going political and policy interest in C&R in the UK. In 2014, the DOH released recommendations about the use of C&R across adult health and social care services (DOH, 2014b).

Due to the access, time and cost implications of translation services, participation was only offered to those with fluent verbal English language.

2.2.2.3. Participant characteristics

In total, 15 SMHNs, aged between 19 and 46 ($M=27$, $SD=9.04$) participated in this study. Eleven participants were women (73.33%). Seven participants (46.67%) had prior experience of working in acute or secure psychiatric settings either before or during nurse training.

2.2.3. Ethical Considerations

The project was granted ethical approval from Coventry University Ethics Committee (Appendix J). Each participant completed an informed consent form (Appendix K)

prior to engaging in the study. The researcher emphasised the right to withdraw, including during, and up to two weeks post-, interview. On completion of the interview, signposting for additional support was given both verbally and via the debrief form (Appendix L).

2.2.4. Procedure

2.2.4.1. Materials

A semi-structured interview schedule of core and prompt questions (Appendix M) was developed in collaboration with the research team to ensure adherence to the principles of effective qualitative research (Brinkmann, 2007). There was flexibility in the guide to allow for additional topics to emerge as raised by participants in their responses. The interview schedule was reviewed by two qualified MH nurses who confirmed the content was appropriate to answer the research question.

The interview schedule focused on the participant's general perceptions of C&R, their perceptions of how they might respond to being actively involved in restraint for the first time, and their perceptions of what support they might need (if any) following this experience.

2.2.4.2. Interview procedure

Eleven interviews were conducted in person at locations convenient to the participant including their placement base ($n=1$), university premises ($n=6$) or own home ($n=4$). The remaining interviews ($n=4$) were completed remotely via WhatsApp Audio (an end-to-end encrypted medium). All interviews were conducted between

January 2020 and February 2020 and were audio-recorded and transcribed verbatim. Interview duration ranged between 14 to 40 minutes ($M=26$ minutes). During transcription, pseudonyms were adopted and identifiable information (including references to specific Trusts, cities, or Universities) was removed to preserve anonymity.

Once the interview was transcribed, the recording was destroyed. Participants were given the opportunity to ask questions or address any issues that arose due to their involvement.

2.2.5. Analysis

2.2.5.1. *Stages of analysis*

Analysis followed the stages outlined by Braun and Clarke (2006) and Guest et al., (2012) and is detailed in Table 9. The process of analysis was iterative: codes, themes, and codebooks were initially tentative, and adjusted as the analysis progressed.

Table 9. Applied thematic analysis process

Stage	Description of process
1- Familiarisation with the data	The initial stage of analysis involved familiarisation with the data whereby the researcher transcribed each interview, listened back to the interviews with the written transcript, and then engaged in multiple readings of the data corpus. At this stage notes indicating initial potential codes were made.
2- Generating initial codes	The initial codes established indicated initial points of interest and were used to help the researcher to arrange the data into meaningful groups. Coding was driven by the data and what is currently known from research about C&R from those with lived experience. All the data was given equal interest: all potential codes were included at this stage, even those which were rejected at a later stage of analysis.
3- Searching for themes	At this stage, codes were grouped together into potential themes. Themes were established by making sense of how codes were interrelated. This included, but was not limited to, repetitions of similar codes. A hierarchy of themes was established: higher-order main themes and lower-order sub-themes. This process was enhanced by using mind-maps of emerging themes which gave the opportunity for some themes to be temporarily moved to a miscellaneous group for further review and to determine whether that theme remained relevant and meaningful.
4- Reviewing the themes	This stage is divided into two sub-stages. Firstly, once initial candidate themes were established, these themes were refined. At this stage, the researcher decided whether the evidence (coded data) does or does not adequately support the theme. This process of refinement ensures that themes are coherent and meaningfully distinct. Secondly, once candidate themes were agreed and collated into a thematic map, the themes were reviewed in the context of the entire data corpus. This helped to establish the validity of themes. On completion of stage four, the researcher (and supervisory team) were confident about how the themes were interwoven and related to meaningfully capture what was conveyed through the data.
5- Defining and naming themes	Each theme went through a further process of refinement and detailed analysis. Sub-themes were utilised to provide structure and a sense of hierarchy within the data. Each theme identified in the current analysis is considered distinct (with minimal overlap with other themes), meaningful and not overly complex. During this stage, the researcher was mindful to maintain the 'story' of the theme as a distinct construct in the context of the wider 'story' of the data corpus. Each theme was given a title which provided the readers with a summary of the theme content.
6- Developing codebooks	The inclusion of codebooks is the defining feature of applied thematic analysis (Guest et al., 2012). Codebooks were used to provide structure for collections of themes which are orientated around discrete subjects within the data. At this stage of analysis, the data was "systematically sorted into categories, types and relationships of meaning" (Guest et al., 2012 p.52). Once codebooks were tentatively established, the data was re-read, and appropriate adjustments were made to the codebook as required. The codebooks served to demonstrate relationships between related themes and helped move the analysis from descriptive to explanatory.
7- Producing the report	The final stage of analysis involved the construction of the analytic narrative to convey a convincing argument that is an accurate summary of the data as related to the research question. The goal of this stage, as determined by Braun and Clarke (2006) is to provide a written account that is "concise, coherent, logical, non-repetitive and interesting" (p.23). The identified themes have been justified through the inclusion of data extracts which evidence the presence of a theme directly in the data corpus.

2.2.5.2. *Reflexivity*

The researcher remained mindful of biases and preconceptions which may have surreptitiously been generated over the course of study development and data collection to legitimately capture the participant perspective. Research supervision, a bracketing interview, audit of transcribed data and a reflective journal were used to ensure fidelity to the research question and aim. The bracketing interview revealed that the researcher had the following assumptions: there is a role conflict about engaging in restraint as a nurse, restraint is anxiety-provoking and that there is limited post-incident support available for staff. During supervision, a further assumption was identified; that SMHNs would benefit from training in C&R.

2.3. RESULTS

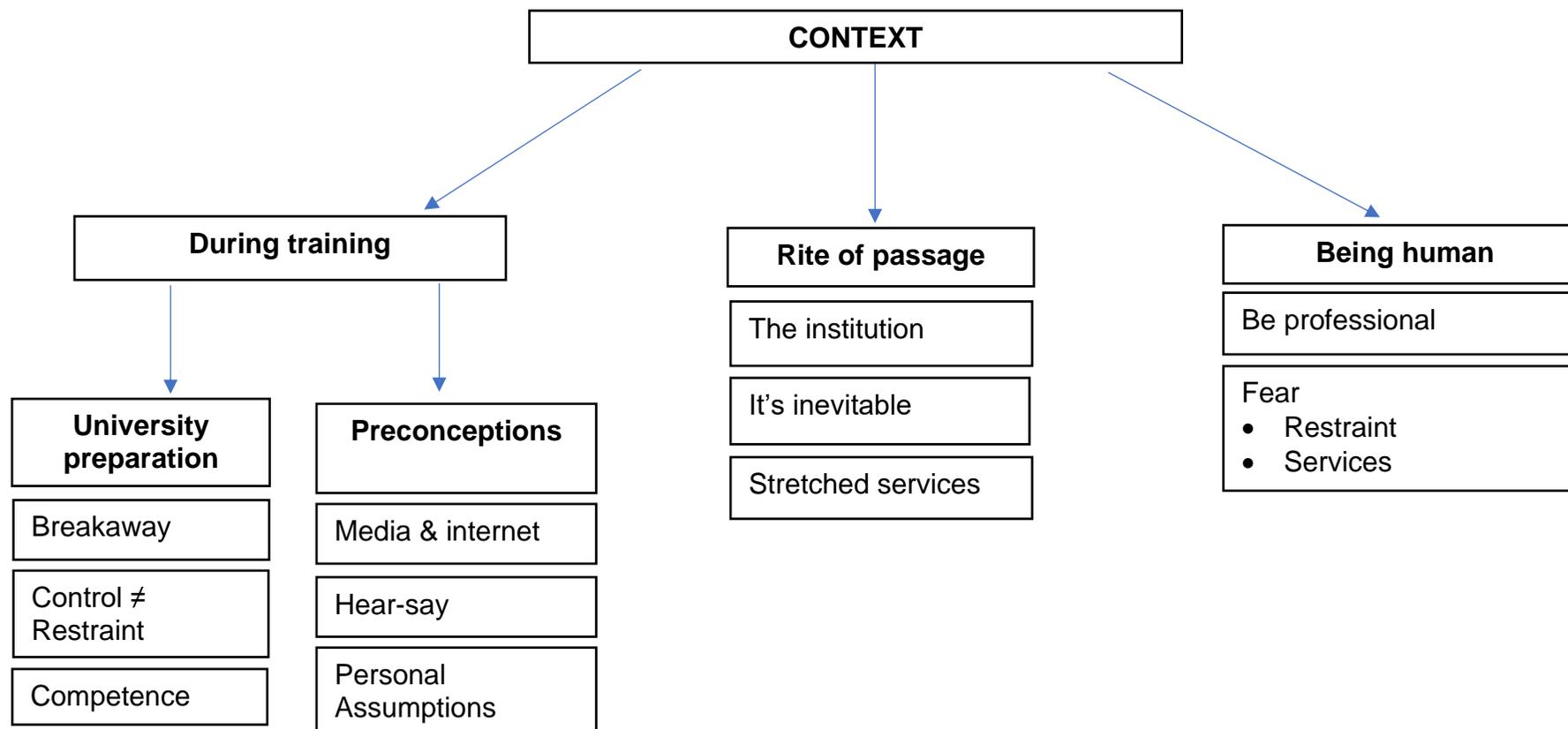
Three distinct codebooks were identified: **Context**, **Moral Dilemma** and **The Aftermath**. Each of these codebooks is presented as a figure and subsequently described with reference to specific quotes from individual interviews.

Appendix O includes further example quotes for each theme and Table 10 which details the frequency of themes across interviews.

2.3.1. Codebook 1: Context

The first codebook (Figure 3) relates to the **Context** in which SMHNs develop an understanding of C&R, how that relates to their career trajectory and the consolidation of their personal and professional identities. This codebook is comprised of three main themes: ***During training, Rite of passage, and Being human.***

Figure 3. Codebook 1: Context



2.3.1.1. During training

The main theme *During training* explores how SMHNs do not exist in a vacuum: as students they are exposed to attitudes, beliefs and facts from various sources including education providers and public opinion. This influenced their expectations and perceptions of C&R and was conceptualised by two subthemes: *University preparation*, a source of informed learning, compared to the *Preconceptions* of the self and others.

2.3.1.1.1. University Preparation

The subtheme of *University preparation* highlights participants' views on the preparation they received from their respective University concerning placement preparation and training in the management of violence and aggression.

There were concerns that, by not being wholly prepared for the eventuality of observing, or being involved in, C&R that SMHNs may inadvertently witness abusive practice.

"I should know that, as a student nurse, if we're gunna be watching these vulnerable people, we should know if they're being abused but we don't know"

Ella (362-4)

Participants stated that the breakaway training they had received formed a basis for their understanding of what C&R meant, and their resultant beliefs about these processes.

“My understanding is probably based on the... limited sort of conflict resolution training that Uni have put on before we go out on placement which has been a three hour session where they’ve qu-very quickly try and get you to learn lots of different techniques, you don’t really drill it or anything”

Nick (81-4)

Molly commented that her experience of observing simulation restraints as part of this training had illuminated the challenge of the process.

“It doesn’t look that nice when it’s just you know, someone that’s having it demonstrated on, let alone [done to] someone who’s really distressed, so I can imagine it being quite a difficult thing to do and see.”

Molly (108-10)

Several SMHNs reported that they understood control to be different to restraint, although some voiced that there is, generally, a misunderstanding, especially around control and its impact on SUs.

“I think we’re very good at identifying actual, erm, kinda, this person was being aggressive and a team of people restrained them or took them to seclusion or stopped two people fighting, so I think, I think we’re very good at identifying what this is, but what I don’t think we’re good at, and what I think happens a lot, is control.”

Lucy (119-22)

Participants reported that SMHNs were sometimes employed as HCAs prior to, or during, their studies. Those individuals had, typically, completed the full training in C&R and were perceived by untrained peers to be more competent and confident in placement settings.

“Some students are on the bank as like an NA [Nursing Assistant] so they have been trained, and they might not have had to use it but they have been trained and I feel like they’re definitely more prepared than I am”

Amy (290-2)

2.3.1.1.2. *Preconceptions*

The subtheme of *Preconceptions* highlights how participants’ personal assumptions, about what it might be like to work in an acute and secure environment, and their thoughts about the use of C&R in practice, were influenced by media outlets, the public, and/ or colleagues.

SMHNs voiced that media portrayals (including video tutorials, podcasts, films, and documentaries) formed a basis for their perceptions of acute and secure mental health services, and the (mis)use of C&R. Some participants stated that they had actively sought further information concerning their specific placement environment.

“Just to see... sometimes I get interested by like um... people’s reviews on um like google maps and things and like, you see, sometimes you get the odd previous patient who’s like ‘oh it’s awful in there”

Cheryl (72-5)

SMHNs reported that members of the public and colleagues alike offered their opinion (without invitation) regarding acute and secure MH units and their assumptions about SU's behaviour.

"I guess violence is always what people think of first... it's always what I'm asked about first, um, as a mental health nursing student people always ask me 'have you ever been hit?'" Emily (96-8)

"you don't want to go into, erm, into a like a male ward because, because men like, throw... I don't know how to say it but like they throw like their body fluids at you" Heather (156-7)

Given the limited formal placement preparation, the beliefs shared with SMHNs influenced their perceptions of their prospective workplace.

"I'd heard a lot of things about acute so I was expecting someone to be like, screaming at the door" Rachel (85-7)

2.3.1.2. Rite of passage

The theme ***Rite of passage*** highlights the SMHNs' perception that working in acute and secure services is a mandatory career milestone. Despite limited appeal of working in these services long-term, participants voiced a shared understanding that they would not be considered 'real nurses' until doing so. Participants understood the acute inpatient environment to be a place which is open to everyone, and where anything can happen.

“It ranged from like 18- year-old boy right to a 60-year-old man and it was like personality disorders, psychosis and, erm, depression and all sorts”

Michael (40-2)

Additionally, participants shared an understanding that these services were enticing with their learning opportunities, including an inevitable exposure to C&R.

“most of the wards where I can learn more, such things are inevitable so I will find myself there”

Freddie (179-80)

Wards were perceived to be under-staffed, leading to less therapeutic environments. Participants also voiced that the wards appeared to be under-resourced to the extent that SUs were being inappropriately placed.

“They [acute wards] are taking people they shouldn’t necessarily – that should be in secure but because of a lack of beds we’re kind forced into having those people”

Simon (27-8)

These perceptions contributed to a wider picture of acute and secure services providing a challenging working environment: the rite of passage for newly qualified nurses.

2.3.1.3. Being human

The theme of **Being human** highlights SMHNs' recognition of an internal conflict between their human nature and professional identity.

“That is not in my nature to put my hands on anybody unless it is in a comforting or loving way so it was a really big barrier for me around... mental health nursing, that that was something you were going to have to do”

Lucy (102-5)

Participants perceived thinking and emotions to be unwelcome during C&R in practice. If anything, connecting with their humanity in the moment was believed to be a barrier to effective, professional nursing.

“It’s more about realising your responsibility, it’s trying to put it to the back of your mind and thinking ‘I’ll reflect on this later right now I need to be here and present’ type of thing. I think maybe it’s more, er, a fight or flight response in that sense and I guess you have to fight in, in the, in the sense of doing your job here and now and the thinking about it later. I’d try my best to not let it overwhelm me too much”

Molly (190-5)

Participants reported being fearful in relation to engaging in C&R and working in acute and secure services. Partly, this represented a fear of the unknown.

“I was a bit scared when I first went to an acute ward... I was like, what’s it going to be like... it’s gunna be chaos, there’s gunna be people being secluded”

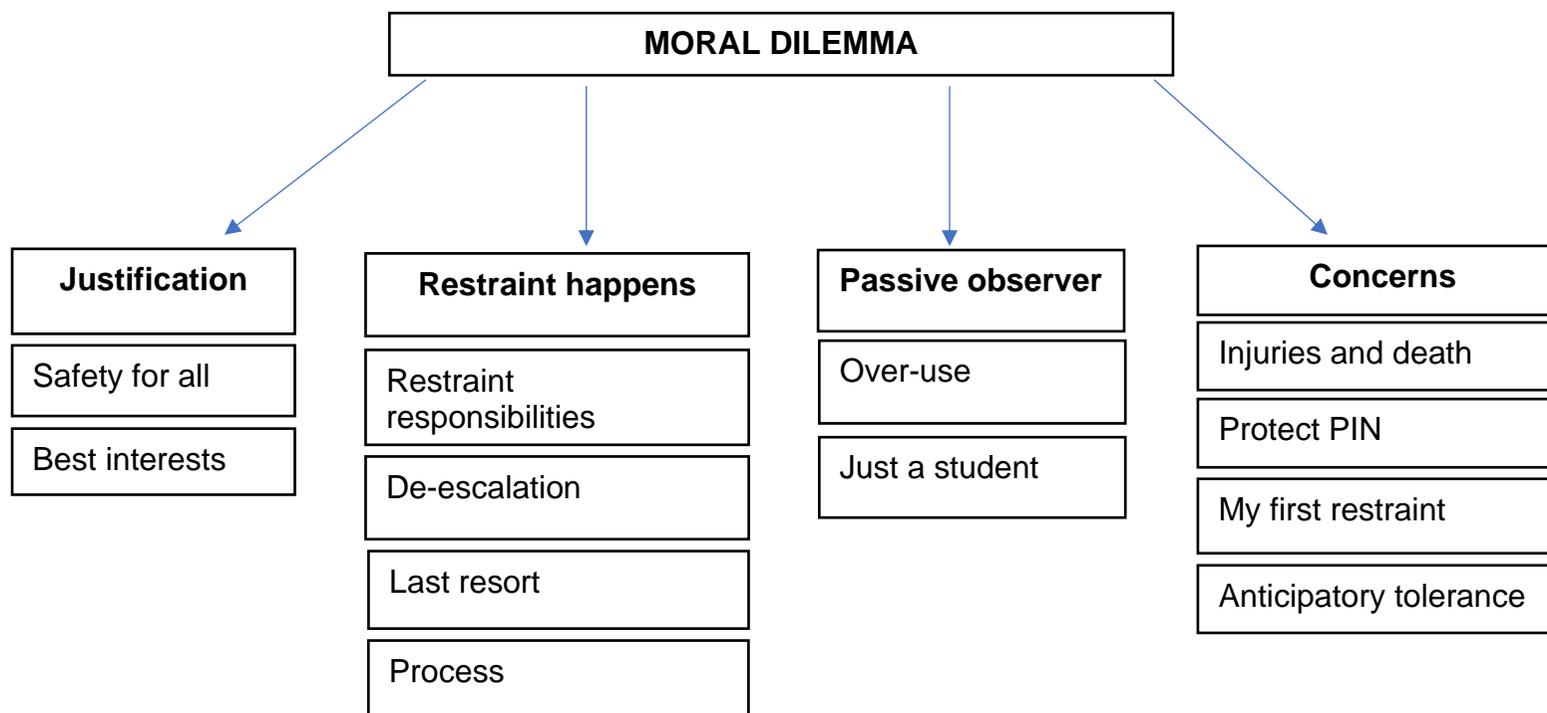
Simon (85-6)

2.3.2. Codebook 2: Moral dilemma

Codebook two (Figure 4) encapsulates themes related to the perceived **Moral Dilemma** of engaging in C&R. Participants reported an awareness that the decision-making process was potentially idiosyncratic, without consistent consensus amongst the team.

This codebook includes four main themes relating to student nurses’ understanding of the **Justification** of C&R practices, the perceived reality when the **Restraint happens**, their status as a **Passive observer**, and their **Concerns**. It considers perceptions about restraint procedures that SMHNs hold in relation to their position as a student, and their perceptions about what it might be like to be actively involved as a qualified nurse.

Figure 4. Codebook 2: Moral dilemma



2.3.2.1. Justification

The theme **Justification** illustrates the participants' expressed awareness that any use of restraint should be appropriately warranted. Some participants were concerned about the ambiguity of justification:

"They've basically said as long as you're not causing them any physical damage, use whatever force is necessary, but I do have concerns about like, well what is necessary?" Ella (110-2)

Participants believed it is justifiable to use restraint to maintain safety.

"If it comes to the point where you know like, the alarm's gone and somebody's in danger or yourself's in danger and you've had to pull your alarm and it happens, even though I might not feel comfortable about it"

Rosie (134-6)

Participants also voiced that there are situations which warrant some form of intervention and are not related to an acute risk. It was hypothesised that this might include intervening in a SU's best interests to prevent deterioration in physical or mental health or exacerbating the SU's vulnerability in some way.

"We'd be doing it in the best interests of the patient, so like if it was the example of feeding, obviously if that person doesn't get food, then they get very ill and then they probably get worse in their mental health as it deteriorates more so it's kinda like the greater good" Laura (144-7)

2.3.2.2. Restraint happens

The theme **Restraint happens** uncovers participants' perceptions of the process around restraint: what it entails and how the participants (as qualified nurses) might be expected to be involved.

Participants understood restraint to be an umbrella term, encapsulating different interventions and used under different circumstances. Some participants stated that physical restraint was also a broad term, with some restraints perceived to be more dangerous than others.

“Unless it’s absolutely necessary you don’t use prone [face-down restraint], purely because of how dangerous it is”

Rachel (279-80)

Others shared their understanding of factors to consider when engaging in restraint; asserting that staff should proactively mitigate against potential consequences for those involved wherever possible.

“We try, to do, to put dignity at the forefront of what we do so we don’t embarrass them in front of everyone”

Freddie (167-8)

Participants voiced that whilst they may understand the conditions under which a restraint would be warranted, they could not always say with certainty that the process was carried out ‘correctly’.

"It's just being sure that it's being done in the right way, whatever way that is cause I don't actually know" Cheryl (99-101)

Participants perceived there to be an important phase prior to engaging in restraint-de-escalation-; intervening before the situation escalates beyond the bounds of safety.

"Talking people down is obviously a massive thing, like you should never jump straight to medication, always try and find out why they're distressed before you know sticking medication in someone, or, uh, restraining them"

Sarah (161-4)

Participants believed restraint to be a last resort intervention: used only when all other avenues have been exhausted. However, what constituted last resort could potentially be inconsistent amongst members of the staff team.

"If there is a risk to someone's life, a risk to self or others then that's when it should be used, but if it's just damage to property, property can be replaced, property can be replaced, you know, it's just a risk to life that's when I feel like it's last resort" Freddie (300-302)

Some participants voiced they had limited concrete knowledge to draw upon when considering the role of a qualified nurse during restraint. This uncertainty was illustrated by the frequent use of language such as "don't know" and "maybe" in relation to their perceived role as a qualified nurse.

“I don’t know if I’d be there to... to like talk to the person while they’re being restrained or, or if I’d be physically have to be active in that and just, I, I don’t even know the logistics of it” Heather (238-40)

Those participants who were more confident in determining nurse-specific roles felt that this would likely involve decision-making and coordination around restraint.

“I definitely think that as a nurse I would be expected to restrain, so like, hold them to a bed, to a floor even, or just hold them so they can’t get off the ward in some way. I think I could be physically holding them, or I could be orchestrating it” Emily (189-91)

2.3.2.3. Passive observer

The theme **Passive observer** relates to the perceptions of SMHNs of their role in identifying and speaking out against malpractice and ward cultures which endorsed frequent use of restraint.

Some participants reported that whilst on placement, they were exposed to a myriad of perspectives and clinical practice. Michael recalled an experience of hearing a colleague openly express eagerness to engage in restraint, he commented that:

“I think it was terrible, I thought... I kept quiet at the time, but I thought that was a disgusting thing to say to be honest” (154-5)

Participants voiced concern about the possibility that, as a qualified nurse, they might inadvertently engage in a restraint that they believed to be unnecessary. There was recognition of the potential to 'follow suit' of experienced members of staff rather than asserting a difference of opinion.

"I don't want to be involved in an unnecessary restraint... I don't wanna, I don't wanna feel that I... disagree with my... certainly as a preceptor nurse, more experienced colleagues, and find myself in a restraint because it's begun and now we can't get back out of it" Lucy (238-41)

Participants identified that their student status can, at times, impede their ability to challenge decisions concerning restraint. Some SMHNs voiced their belief that they may have the knowledge to recognise poor practice, and personally not feel able to challenge this.

"If I felt, like, at the time, if it wasn't necessary, I'm not sure if I would speak up, if you know what I mean. I'm not sure I'd have that candour to say" Rosie (161-3)

2.3.2.4. Concerns

The theme **Concerns** highlights some of the personal and professional implications of being actively involved in restraint as shared by the participants.

SMHNs perceived the experience of engaging in restraint for the first time to be anxiety-provoking and would likely result in them feeling upset afterwards.

“I think I will be very upset the first time that I have to do it and also probably very nervous” Rachel (229-30)

Some participants thought that the experience might be enhanced by looking to more experienced staff for guidance. Nick highlighted that this could be problematic as it would rely on the individual nurse making a judgement about their colleagues being appropriate role models, acting with integrity:

“if there’s other people there who’ve done it before I might be less anxious and I’ll probably be looking to them to follow them, but then, if I, dunno [laughs] if I work with people who I’ve decided they’re not the sort of people I want to following their example I’d probably be really worried about it”

(145-9)

SMHNs voiced the potential for life-threatening consequences of physical restraint and medication errors in chemical restraint.

“if done improperly people have died from being physically restrained so that’s the worst-case scenario for sure. Um... things can go wrong in the hustle and bustle like medication errors” Simon (168-170)

The risk of accidental injury when engaging in physical restraint, sustained by anyone involved (the SU being restrained, the nurse or other team members) was also highlighted:

“I’d hate to accidentally hurt the per-the patient that was being restrained... I’d hate to, you know, for someone to get hurt, like for me to get hurt, or for someone around me, like one of the other patients to get hurt”

Heather (254-7)

Participants expressed an awareness of potential professional ramifications of engaging restraint, such as allegations being made by a SU who was subjected to this.

“one of the patients, erm, erm, alleged that they mishandled them during a restraint ... she said ‘oh they dragged me’ which, it wasn’t dragging, but it was some sort of manoeuvre but other people saw it as... as dragging on the floor”

Freddie (137-41)

SMHNs were also concerned about the potential of losing their nursing registration following allegations.

“What happens if you get struck off? And I guess it’s quite a selfish concern to have but I, like, you know, I’ve put a lot of work to get here and I don’t want me injuring someone to make me not right for the job”

Emily (240-2)

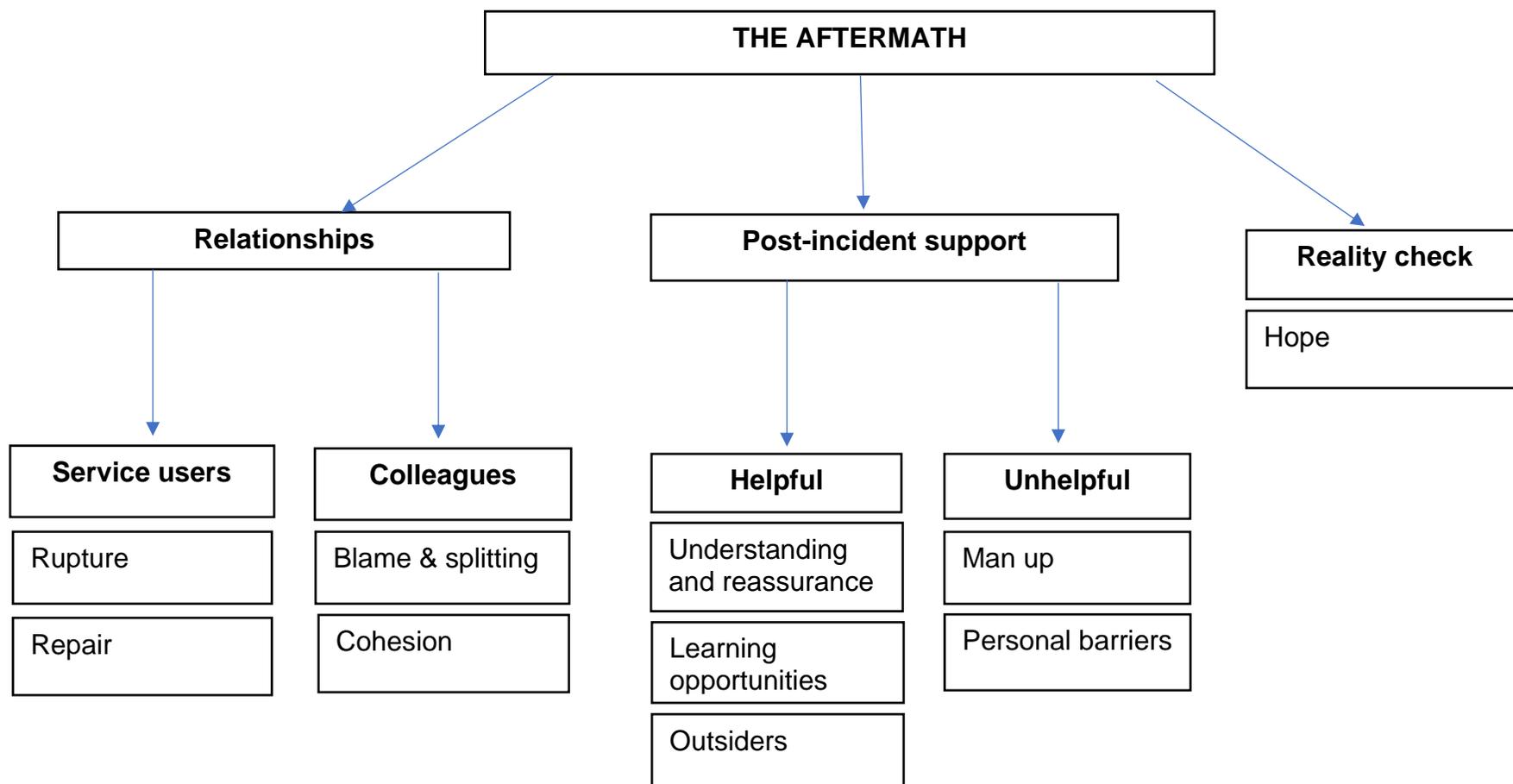
Some participants perceived that, whilst their first experience of restraining someone might be anxiety-provoking and upsetting, there could be a time when this was less emotionally intense. Laura reflected:

“I think it’s a good thing and a bad thing cause obviously the more you do something the less empathy you’re gonna have in the situation which does mean that you’re probably less likely to identify with the patient but then at the same time, the situation, it will be safer cause I wouldn’t be as nervous... about... restraining someone” (228-32)

2.3.3. Codebook 3: The Aftermath

The final codebook (Figure 5) explores participants’ perceptions of **The Aftermath** of engaging in restraint as a nurse. There are three main themes in this codebook: **Relationships** which reveals the perceptions SMHNs hold about the relational impact of restraint, **Post-incident support** which highlights the preferences and concerns that participants have about their emotional well-being after involvement in restraint and **Reality Check** which encapsulates perceptions about the reality of C&R in practice.

Figure 5. Codebook 3: The Aftermath



2.3.3.1. Relationships

The main theme of **Relationships** encompasses the two main relationships that participants perceived to be affected by restraint. As such, two subthemes were identified: *Service users* and *Colleagues*.

2.3.3.1.1. Service users

The subtheme *Service users* highlights SMHNs' perceptions of their relationship with the SU following involvement in restraint.

"If somebody's got no insight into their mental health condition then they're not going to understand why you're restraining them and grabbing them, and so they'd be as angry as I would if you grabbed me right now [laughs] so that's definitely going to be negative and I think even, even if someone does understand I just think... there's probably something deep within in where we don't like to be physically dominated by other people and there'd be some sort of resentment toward someone who, people who did that to us"

Nick (176-182)

Participants expressed consensus that restraint potentially hinders the therapeutic relationship by diminishing the trust SUs had in their nurse although many felt this was reparable. However, participants also voiced concern that SUs may perceive nurses who engage in restraint as abusers and complicit in impeding their recovery.

"If that was a patient on my caseload and I had hurt them that loss of trust and loss of rapport would then mean that they might have to change nurses and

that might mean a slower recovery process for them and they wouldn't get better as quickly" Emily (250-3)

Many participants shared a belief that nurses should focus on helping the SU to understand why the restraint happened, emphasising that this came from a position of care. Participants highlighted that relationship repair would be more effective if done collaboratively.

"I think they'd appreciate it more if you come to them and talk things through with them and say I, you know, I didn't want that to happen, but this is sort of what led up to it... what do you think? What could improve the situation for you?" Sarah (265-8)

2.3.3.1.2. *Colleagues*

The subtheme *Colleagues* illustrates the SMHNs' perceptions of how an experience of restraint can potentially enhance teamwork or cause a rift between team-members.

Nursing was perceived by participants to be a community with a distinct in- and out-group.

"the impression I get is that there's always going to be a dominant culture within a team on each ward and... if you didn't agree with what they thought I think you would struggle to find somebody to empathise with you"

Nick (223-6)

Participants cited the importance of teamwork and the potential for splintering across the team when a shared approach is absent. Some SMHNs noted that the variable willingness of staff members to engage in restraint could lead to a negative reputation of that individual. The concerns that participants had about blame within the team encompassed both the risk of being the individual blamed and having to apportion blame to another.

“There’s always that general fear of if you, if someone does something and maybe, you have to report them then obviously that can cause [laughs] relationship problems”

Heather (322-4)

Participants also noted the potential for a shared experience to bring the team together, enhancing trust in colleagues particularly if there was consensus about the use of the intervention and there was space for reflection afterwards.

“If they’re a strong team and a nice team and they understand what you’re going through that it would make you a bit stronger as a team, talking about your feelings around restraint, understanding how everyone feels about it, and also knowing that restraint as a team would hopefully be a last option so hopefully understanding the processes as a team together”

Molly (256-60)

2.3.3.2. Post-incident support

The theme ***Post-incident support*** refers to SMHNs holding the perception that restraint would be an anomalous experience. Consequently, having a dedicated space for processing and reflecting on the experience was believed to be valuable.

Two subthemes were identified: *Helpful and Unhelpful*.

2.3.3.2.1. Helpful

The subtheme *Helpful* reveals what participants perceived to be beneficial in consolidating a lived experience of restraint.

Participants consistently reported that debriefs and clinical supervision with senior colleagues would be beneficial, either as a group or in one-to-one sessions. Without this, nurses were perceived to be left in a vulnerable position where the pressure of the role overwhelmed them.

“You have to have the backing from the people above you so that’s why people are quitting nursing... they qualify after two-three years they feel like nope, I can’t take it anymore cause it’s too much pressure”

Freddie (L400-2)

Participants believed they would benefit from the understanding and reassurance of experienced colleagues, especially after their first experience of restraint. SMHNs identified that having the opportunity for learning and identifying ways to improve future practice (rather than dwelling on mistakes) would be well-received.

“Supervisions with other nurses and management and HCAs, thinking about how we could have avoided that, or how we could’ve done better... it’s just I always like to do things and like to improve myself and learn constantly, constantly, I love learning so yeah just through meetings afterwards cause I think, if I felt like I’ve done something... wrong and I can learn from that, I think that helps me a lot” Simon (262-6)

There was agreement amongst participants that family and friends, as neutral outsiders, would be consistently supportive despite their potential lack of knowledge and experience in the field of mental health nursing.

“probably quite good actually to talk to people who aren’t in that world of work because, I don’t know, they... it’s an unbiased person ... yeah I’d talk to friends” Sarah (378-80)

2.3.3.2.2. Unhelpful

The subtheme *Unhelpful* explores the perceptions that participants hold regarding what would be a hindrance in terms of support offered, and the potential barriers to feeling able to access available support.

Several participants perceived that there may be a tendency to be told to get on with their jobs after being involved in restraint. There was an appreciation of the irony of accepting that C&R is an inevitable aspect of the job and the reality of being confronted with the same sentiment post-incident.

“People sayin’ ‘it’s just part of the job’, people saying, um, ‘it comes with the territory’ thing, which I guess is what I’ve been saying since the start of this interview [laughs] but I wouldn’t want people to say that to me”

Emily (368-70)

Participants identified that sometimes support might be offered and available, but their own beliefs about what might meet the threshold for accessing this could prevent them from doing so.

“Even as mental health nurses, we don’t put, we don’t put our own mental health first. Um, I know, yeah, it’s always not bad enough”

Amy (L374-5)

2.3.3.3. Reality check

The **Reality check** theme highlights the SMHNs’ perceptions about the likely reality of working in services where restraint may be used and experiencing this first-hand. Some felt that staff well-being was a priority particularly within mental health:

“In mental health they are really good at supporting people, um, and there’s a big drive to make sure staff’s well-being is taken care of”

Laura (282-3)

Others were sceptical about whether the resources to facilitate this exists.

“I kind of feel like there probably isn’t as much support available as I would like, erm, because... everyone’s just so busy and I feel like with things like that it just happens and then everyone just gets on with their day”

Heather (376-8)

Repeatedly, participants spoke about ‘hope’ for their futures as qualified nurses. This spanned hope for; a competent team to work alongside, understanding from colleagues about the emotional impact of restraint, and advances in clinical care which reduced the use of C&R. This hope was perceived as somewhat of a caricature by Lucy:

“I’d love to live in a [laughs] panacea world where every ward that I ever work on has beautifully calm patients, and none of us ever need to do it because it’s not a pleasant experience” (226-8)

2.4. DISCUSSION

SMHNs perceive C&R to be an unpleasant, yet inevitable, feature of their future career. The results of the current study suggest that SMHNs do not consistently feel prepared for working in acute and secure settings, despite highlighting the expectation of doing so as a rite of passage into nursing.

The SMHNs’ understanding of what is meant by C&R, and what their role in the process may be, was variable. This supports previous literature asserting that these processes are poorly conceptualised by those who may use them (Kinner et al., 2017). Participants understood *control* and *restraint* to be distinct but interconnected

terms. The former related to the restrictions placed on SUs in the acute and secure environment and the latter concerning physical, chemical, and environmental interventions used as a last resort to manage risks or in the SU's best interests.

SMHNs were aware of the wealth of information available to them (fiction and non-fiction, reliable and unreliable sources) and were eager for more formal training, recognising a disparity between their expectations (influenced by cultural preconceptions) and the reality.

Participants voiced fears about engaging in restraint as a qualified nurse. The moral dilemma is consistent with previous research exploring the qualified nurse position (Vedana et al., 2018), and suggests that these concerns emerge before lived experience of such practices. Significant concerns expressed in the current study were the potentially life-threatening consequences of physical restraint, and the professional implications of (actual and alleged) errors in the use of restraint.

Experienced practitioners were positioned as role models by the SMHNs. However, some participants expressed concern about the behaviour of other practitioners including overt enthusiasm for restraint. SMHNs highlighted that they may not be able to confidently assert that the appropriate course of action has been taken. Consequently, they are left vulnerable to inadvertently observing abusive practice.

The SMHNs in the current study anticipated C&R to have relational consequences. It was understood that such interventions would likely have a detrimental impact on the therapeutic relationship between SU and nurse. This is reflective of previous

literature which highlighted the nurses' role in resolving or further impeding the therapeutic relationship in the context of restraint (Bonner et al., 2002). Furthermore, participants identified the potential for C&R to be a source of conflict or cohesion amongst colleagues.

Participants felt that a crucial aspect of the process of engaging in restraint was the facilitation of meaningful debriefs for all involved. Principles of validation (of the anomalous nature of the experience, and the emotional impact) were highlighted as key components of post-incident support. This is an important finding as the literature indicates that more experienced nurses view restraint as part of their role (Bigwood & Crowe, 2008), whilst also recognising that the emotional impact of the process is longstanding after the event (Bonner et al., 2002).

2.4.1. Clinical implications

SMHNs would likely benefit from receiving full training in C&R, and this is advocated for by SMHNs themselves. Such training should not impact on SMHNs' supernumerary status: the function is to enhance learning, not for SMHNs to become additional 'hands' to relieve, what are perceived to be, stretched services. SMHNs in the current study recognised C&R to be a multifaceted process and therefore training interventions would benefit SMHNs by developing their understanding across each of the component parts.

Firstly, SMHNs could be supported to develop skills in proactive management of violence and aggression. SMHNs in the current study recognised that there are important processes preceding the use of restraint specifically, although they were

unclear on the intricacies of these procedures. Training might be aimed at supporting SMHNs to be able to identify and appropriately respond to a SU's triggers and early warning signs in a way that maintains the SU's human rights and dignity (Ridley & Leitch, 2020). To complement this, SMHNs could be supported to develop of a 'toolkit' of skills for de-escalation including distraction techniques and validation of distress (DOH, 2014b). These transferable skills can be employed by SMHNs at any stage of training and in any clinical setting and may serve to bolster SMHNs' confidence: moving from passive observer to active practitioner.

Secondly, SMHNs' attendance at a standardised C&R training programme might improve their confidence in knowing what this involves given the inconsistent understanding currently held by SMHNS in this respect. It is important to re-iterate that guidance on training programmes in the UK have only recently been published and subsequently adopted by the CQC (Ridley & Leitch, 2020). This guidance has offered some clarity on the form and content of C&R training, although it is not prescriptive. Additionally, training continues to be delivered by a range of training providers who adopt different techniques and practices. For example, some providers do not teach prone restraint (identified in the current study to be a particularly risky form of restraint), whilst others do.

The DOH guidelines similarly offer a framework and set of principles to be used by a range of stakeholders (including individual practitioners and C&R training providers) rather than a prescriptive training programme to be adhered to (DOH, 2014b). Since SMHNs perceive aspects of C&R to be ambiguous, a flexible framework may not be sufficient in up-skilling this population. Instead training should offer more clarity

regarding what would and would not meet the threshold for C&R interventions. The lack of consistency in training currently in the UK would indicate that further advancements would be beneficial. This may include offering a decision tree with clear case examples (of best practice and poor practice) identifying different potential courses of action and their potential outcomes. It should include the process for raising concerns should the SMHN perceive the actions of others to be inappropriate or abusive.

When considering the practical process of restraint procedures, training should identify key roles of mental health nurses such as leadership and medication administration. SMHNs should subsequently be provided with opportunities to develop and refine these skills and to evidence proficiency as would be expected for other domains during nurse training (NMC, 2010). Applying social learning theory (Bandura, 1977), and in the context of previous research (Erkil & Korkmaz, 2009), it is important that SMHNs are provided with opportunities to observe others alongside receiving structured learning and direct experience (simulation or otherwise). Without the latter, SMHNs are vulnerable to adopting attitudes and practices which are potentially abusive in nature as they are not offered the counter argument to the notion 'restraint is inevitable'.

Finally, consideration should also be given to the post-incident period for both SUs and staff alike. SMHNs in the current study recognised the inter-personal consequences of restraint for their therapeutic relationships. Previous literature concerning therapeutic ruptures indicate that it is paramount that practitioners recognise the rupture, and approach therapeutic repair with empathy and a desire to

collaborate on understanding the rupture non-judgementally in order to move forward (Bullard & Grist, 2014). Focusing on the core therapeutic skills underpinning this process (reflection, validation, empathy) with explicit consideration of how these can be applied to the rupture and repair of relationships following C&R would promote professional growth of SMHNs.

Staff support could be enhanced through changes to the form and function of supervision and post-incident debriefs. SMHNs anticipated that they may become more tolerant to engaging in restraint over time believing this to be both beneficial and problematic. They believed debriefs may be offered intermittently rather than routinely, which may perpetuate the sense of normality regarding the implementation of restraint in practice. There is a need to provide nurses with support which promotes professionalism and humanity when approaching C&R. That is, supporting individuals to be emotionally resilient enough to perform the duties of their role, without becoming complacent about the use of C&R in practice; a concern that SMHNs had both observed, and considered. In part, this may be achieved through debriefs and supervision which give the individual permission to have a human reaction to the experience knowing that validating support focused on growth and personal development is available. In addition, this would model the expectation that training in C&R is not a static, 'tick-box' exercise and that it requires on-going consideration and exploration. As such, SMHNs would be better equipped to actively participate in the on-going culture change needed for reducing restrictive practices in acute and secure services (Ridley & Leitch, 2020).

2.4.2. Limitations

Predominantly the limitations of this study relate to the sample characteristics. The mean age of participants in the current study is older than the typical age bracket of SMHNs enrolled on nurse training programmes which is 18-25 (Universities and Colleges Admissions Service, 2018). This may have implications in terms of preparedness for the environment and previous (life and employment) experience which influenced their perceptions of C&R.

Furthermore, the observation of C&R did not preclude participation in the current study. The frequency of participants being exposed to C&R as an observer was variable among the cohort. The variety of experiences that SMHNs had is likely to have influenced their perceptions.

In terms of procedure, those interviews which were conducted remotely may have been limited in terms of rapport-building and access to non-verbal cues due to the researcher and participant not being face-to-face.

2.4.3. Future research

Whilst the SMHNs in this sample speculated on what it might be like to be involved in restraint for the first time, there is currently no qualitative research regarding initial lived experience. Exploring the transitional phase from SMHN to qualified nurse could highlight potential areas of support which facilitates retention of nurses during a risk period for intention to leave (Yeh & Yu, 2009). This may also illustrate how nurses consolidate these experiences and continue nursing: bridging the gap

between what is known about the experience of long-term staff members, and the perspective of inexperienced SMNHs.

SMHN with lived experience represent another dimension of the student position on perceptions of C&R. Inclusion of their voice would contribute to a holistic understanding of the SMHN perspective.

2.4.4. Conclusion

SMHNs perceive C&R to be an inevitable feature of their future career, although many did not understand what this might involve. The interventions were deemed to have personal and professional consequences for both SUs and staff alike. SMHNs were mindful of the relational impact of restraint on the SUs and considered the repair of therapeutic ruptures to be a collaborative process.

There is an on-going need to provide SMHNs with protected learning environments which equip them with the relevant skills and prepare them for the reality of qualified nursing. Providing training in C&R may improve SMHNs' understanding of these practices and is considered advantageous by those without this training. Improved knowledge of the processes may bolster SMHN's confidence to identify appropriate role models during training and to speak up against abusive practice should they witness this. Additionally, honing skills in the reparation of therapeutic relationships (following rupture resulting from C&R use) would be advantageous to SMHNs and SUs alike and may contribute to a wider culture change, underpinning a reduction of C&R. Promoting the facilitation of supervision and debriefs may be beneficial for

building emotional resilience especially if they comprise a reflective and validating space for individuals, and teams, to learn and overcome challenges.

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3.0. CHAPTER THREE:

Am I a researcher? Making sense of a new identity

Word count: 3556 (exclusive of figures, footnotes and references)

3.1. Introduction

Reflection is considered a fundamental process in Clinical Psychology, with the British Psychological Society (BPS) recognising the role of reflection in maintaining registration as a Health and Care Professions Council (HCPC) clinician (BPS, 2017). Interestingly, engaging in a process of reflection for personal and professional growth is known to come with challenges for Trainee Clinical Psychologists (Gillmer & Marckus, 2003). It is argued that the process can be somewhat de-stabilising in terms of encouraging the individual to deviate from the proficient role assumed during the application process to the uncertainty of trainee status (Gillmer & Marckus, 2003).

Despite acknowledgement of the importance of reflection, it is also recognised that the demands of clinical psychology often supersede opportunities to engage in this process (Bennett-Levy, 2003). Throughout clinical training I have been afforded the opportunity to pause and reflect, a seemingly privileged position to my qualified colleagues. The experiential nature of embedding a process of reflection has also been an opportunity to acknowledge the interwoven connectedness of the different components of both my personal and professional identity.

Personally, reflecting during my journey through research has been an opportunity to distance my expectations and perceptions of my capabilities, and the reality of completing these projects. In my first reflective submission on this course, I recognised my propensity to be self-deprecating and the potential for self-reflection to become ruminative: a counter-productive endeavour which impedes growth and creativity (Takano et al., 2011). I committed to adopting a more 'realistic lens' when

considering my own practice, especially in identifying and valuing my strengths. Without doubt, my conviction in this assertion has wavered throughout this process and I have struggled to maintain sight of my strengths at times.

3.1.1. ACT-informed reflection

The following reflective account has been conceptualised using Acceptance and Commitment Therapy ([ACT]; Hayes et al., 1999) – a model which has dominantly featured in my reflective and research journal entries throughout training. ACT as a model was personally appealing because it is relational, contextual, validating of the human experience and focuses on the workability of human behaviour (Hayes et al., 2006). It supports movement toward a meaningful life by targeting six processes: acceptance, cognitive defusion, present moment connection, self-as-context, values and committed action (Hayes et al., 1999). This seemed particularly pertinent to my journey through research: an experiential process of connecting to each component of the model.

3.2. My researcher identity: a stuck cycle – where do I go from here?

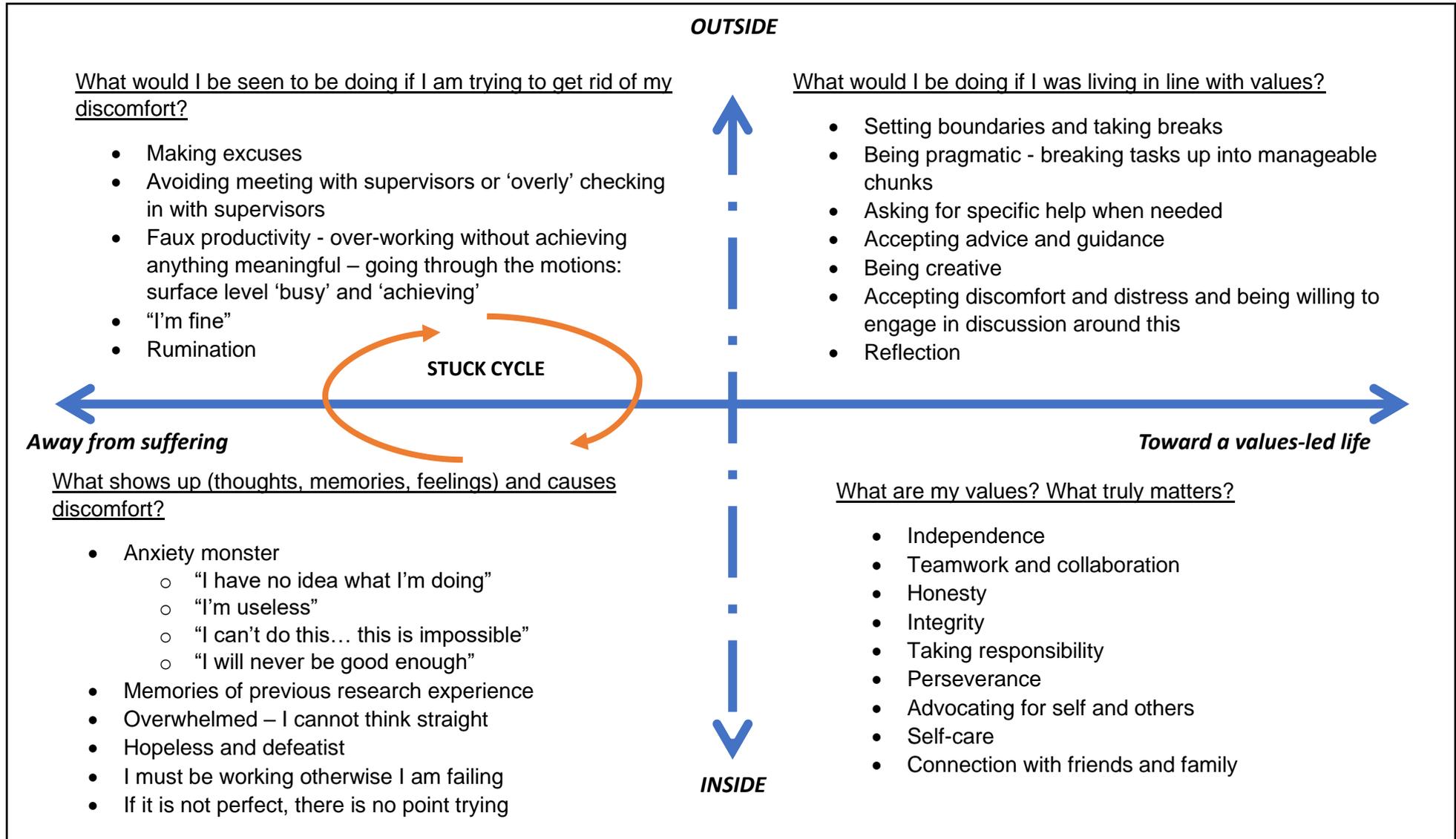
My earliest experiences with research (during my undergraduate studies) were frustrating. Having been confident in my academic abilities until that point, I found the whole process anxiety-inducing. I was unsupported in my supervisory relationship and, instead of challenging this, I withdrew, and passively completed my project. I was not proud of my research and I felt disheartened by the critical approach of my supervisor. Research was not for me. This belief, if left unchallenged, had the

potential to lead to repeating ineffective patterns of behaving, inviting recurring self-judgement and criticism (Polk et al., 2016).

I approached the prospect becoming a researcher, as part of my clinical training and professional identity, with dread. I was aware that there was an elephant in the room I had not made space for. I appreciated my supervisory team facilitating the formulation of my researcher identity, in the context of past experiences, and collaboratively developing a shared language for moving forward (Walker, 2009). The relationship with my supervisors served as an anchor for emotion regulation, reflection and learning at times of uncertainty (and associated anxiety) throughout the thesis. Experientially, there was a noticeable shift in the construct of what it meant to engage in research. That is, it could be a process conducted within a supervisory relationship which fostered learning and emotional well-being.

A tool I have found useful both personally and professionally throughout training has been the ACT matrix (Polk et al., 2016). I benefit from visualising challenges I face, and this seemed like an appropriate starting place for making sense of my research related anxiety – mapping out what matters and exploring what shows up internally, and impedes living in line with my values (Figure 6).

Figure 6. ACT Matrix



This process illuminated one particularly important ‘stuck cycle’. For me, this was a clear illustration of me engaging with the illusion of control (Harris, 2019): that I get caught in an unhelpful cycle of experiential avoidance I have come to identify as ‘faux productivity’. In those moments I find myself continuing to ‘just keep working’ in the face of anxiety and utter bemusement. In part, I do this in the vain hope it will amount to something – retrospectively, it would almost always have been more helpful to pause and reflect before attempting to problem solve.

I recognised parallels between my own stuck cycles, and those that I had worked through with various clients in my clinical work. My inclination to focus on the (seemingly unobtainable) end goal, and the (perceived) gruelling journey to get there became a barrier to connecting to the present moment. Reflecting on my clinical work, I was able to experience the importance of connecting to the present moment and noticing my patterns of behaving in order to move from autopilot, unworkable cycles to workable, values-led living.

In addition, this process also cemented the significance of having a clear understanding about the function of my behaviour without judgement. Reminding myself that what I do is not inherently good or bad gave me permission to explore what is driving me to behave as I do and whether, fundamentally, this is workable. Utilising creative hopelessness⁶ (Blackledge and Hayes, 2001) I was able to recognise how my experiential avoidance, when the anxiety monster turned up,

⁶ Creative hopelessness entails exploring the workability of behaviour. Behaviours which are strongly reinforced, usually as a product of reinforcement of the short-term relief that it brings, are often engaged with on an almost automatic, unconscious basis. This can, however, come at a cost, and the function of creative hopelessness is to identify what those costs might be and whether the short-term relief converts into long-term change or, instead, perpetuates stuck cycles of experiential avoidance.

provided short-term relief, but never truly banished the monster. My relationship with the monster needed to change. I might not be able to get rid of it, but I can choose to navigate toward what matters: with my monster being a co-pilot rather than a dictator.

Identifying my 'why', and connecting with my wider values, was the important first step to becoming (helpfully) unstuck.

3.3. Why control and restraint?

It was evident that my values base led me toward control and restraint as my research topic. My interest in control and restraint stems from my own professional experience prior to training. Having worked predominantly in Forensic Mental Health and Learning Disability inpatient settings prior to training, this was something I was frequently exposed to. Personally, I found this to be one of the most challenging aspects of my role.

The internal conflict of 'putting hands on' people and being complicit in the involuntary medicating of clients sat uncomfortably alongside my role supporting the same individual toward rehabilitation and recovery. My drive to advocate for others led me to passionately campaign at work to reduce restrictive interventions and to contribute to a proactive and empowering culture of care. I worked closely with the multidisciplinary team (MDT) to implement clinical recommendations derived from investigations following the Winterbourne View scandal (*Positive and Proactive Care: Reducing the Need for Restrictive Interventions*, Department of Health, 2014).

During this process, I became more aware of how others approached control and restraint. I was curious about my observation that several of my support worker and nursing colleagues had very different attitudes to me. For some, the idea of engaging in control and restraint was an inevitable part of the job – something they did not like but seemed to actively choose to pay little attention to. Whilst I was not personally exposed to abusive practice of control and restraint, the idea that someone could physically or chemically restrain another individual and think nothing much of it, jarred with me.

When formulating my research question, these themes kept repeating – it mattered to me to contribute to the literature on control and restraint. I was interested in where this attitude, or maybe coping style, came from. It made me think of my first interview to work in forensic services, where I was explicitly asked what appealed to me about working in an environment where I was likely to be assaulted and would be paid less than if I worked in a supermarket. This question has always stuck with me. For me, what appealed was making sense of how people might come to be in a unit like this and contributing to that individual's journey of recovery and rehabilitation (whatever that might look like). Of course, I was also pursuing a career in clinical psychology, and this was also an opportunity to work with a clinical population I had not previously worked with. I wondered about what other people's motivations might be to work in these environments and whether this influenced the ward culture.

During the process of refining my research question, I was surprised to learn that student nurses are somewhat protected from the reality of control and restraint, never formally being taught the process and principles. Instead, they are given just

enough knowledge to keep themselves safe through breakaway techniques. This seemed like an interesting place to begin – how might control and restraint be understood by those who have never experienced it yet are pursuing a career which might involve this?

3.4. The reality of research: what really matters?

3.4.1. Authentic connection

I found it beneficial to put my research in a wider context when considering what it is that drives me in this process. Of course, my thesis benefits me in a clear way: it contributes to the completion of my doctorate. However, my reflections throughout this process made it very clear to me that this was not going to be enough to ‘get me across the finish line’.

It became clear that for every decision made and internal conflict resolved during my research journey, new challenges arose. In keeping with ACT, I attempted to approach each with curiosity, attempting to identify the values guiding my actions and whether the strategy I employed was workable. This included the fact that, once I asserted that I wanted to pursue a research topic that resonated with me on a personal level, I was subsequently faced with the challenges associated with this.

For example, my epistemological position leant me toward qualitative approaches which engaged with nuanced and powerful accounts of life (Black, 2006).

Quantitative approaches seemed too reductionist for something so personal. This in turn revealed my concerns about the ownership of the voices being shared. Of

course, they were not my voices: I am not a nurse. I was conflicted about the potential authenticity of telling someone else's story, whilst simultaneously having a platform for doing so.

Being personally connected to my research and aware of the associated conflicts provided an experiential opportunity to understand the value of reflexivity in qualitative research (Binder et al., 2012). This included bringing my awareness to the influence I, as a researcher, had on the participants I interviewed, and the reciprocity of this exchange (Jack, 2008). The idea of holding my position as a researcher sat somewhat at odds with an ACT perspective. In ACT-congruent therapy, self-disclosure is considered a vehicle for moving a client forward and in the development of human connection between the therapist and client (Polk et al., 2016). In contrast, such disclosures would likely have influenced what was shared by participants and undermined the fidelity of this qualitative enquiry (Jack, 2008).

Research supervision was invaluable in being able to tread the line between connecting to my values and undertaking qualitative research. This required openness and awareness – for me to express my internal world and be willing to be challenged on my decisions throughout the process. In part, this was supported by a bracketing interview which served as a concrete reminder of my assumptions and beliefs about a topic area that meant something important to me. Whilst I found the bracketing interview beneficial, it took time to adjust to being challenged on my decisions. Initially, being asked to justify my decisions brought anxiety, self-criticism, and judgement. I construed the process as a reflection of poor decision-making and failure rather than an important part of reflexivity in research. Being candid about this

with my supervisors served to facilitate a change – some appropriate reassurance was gladly received, and my curiosity was reinstated: *how did I reach that conclusion? Is this coming from me or my data?* All of which contributed to a better understanding of the relationship between researcher and participant in qualitative research and the value of supervision and reflexivity in conducting meaningful and rigorous research.

3.4.2. *Professional development*

It was also important to me that I approached the process of completing the thesis as an opportunity for professional development. An important part of this process having meaning was about embodying my commitment to be a contributor as well as a critical consumer of research. As a clinician, I have repeatedly found myself frustrated at the paucity of literature on a range of topics and this is something I have discussed in several forums. I was determined to take advantage of the opportunity open to me to work with experienced researchers as a stepping-stone toward engaging more confidently with a researcher identity in the future.

In one of my first research journal entries I reflected on something I discussed during my research interview for training – an article I had read in the *Journal of Applied Psychology* (Kozlowski et al., 2017). In this article to mark the centenary of the journal, the authors analysed trends in the literature that had been published over the last 100 years. One of their findings was that authorship noticeably increased whilst single author articles were a rarity (Kozlowski et al., 2017). At the time, I had taken comfort from the idea that research could be a collaborative process – I did not need to know all the answers or ‘go it alone’. This contributed to a more realistic

appreciation of the research process which in turn reduced some anxiety around this.

Again, it was important to make sense of the function of this perceived comfort. That is, when I felt contained by the prospect of a collaborative research process, I was better placed to take opportunities for independently developing my personal research skills. The balance I strived for (in line with my values) was being autonomous and responsible for my research process, whilst confidently being able to ask for help when I needed it. Consequently, I was better positioned to open up to the opportunities for professional development during the research process.

3.4.3. *Personal growth*

Almost inevitably, with professional development came personal growth. This process has been a substantial learning curve when it comes to what truly matters to me as an individual. At the outset of training, I was so grateful for the opportunity that I, in hindsight, neglected almost everything that mattered to me – prioritising work over most other things.

That was never going to be sustainable and I am glad that I took time at the beginning on this journey to map out my matrix. Being able to visualise the importance of setting, and maintaining, boundaries around my work facilitated my connection with the people who mattered (friends and family). It helped me to move from a position of continual and unfruitful work to efficient work with a healthy balance of play. It felt like a long time coming but learning to balance all the

demands of clinical training, and not becoming a slave to the process, has been a lesson well received.

3.5. Passengers on the bus: When things go ‘wrong’

There came a time during my empirical project recruitment when my perceived ‘worst-case scenario’ was imagined. I had to change my project due to the time constraints of completing a thesis with no uptake from potential participants. I had intended to explore the early experiences of qualified nurses who had engaged in control and restraint for the first time in their first post-qualification year. Initially, the gravity of the situation (effectively abandoning the project) felt overwhelming. Whilst I was supported with making this decision, and was clear in the rationale behind it, the reality was frustrating, almost painful. Not only did this feel like a dis-service to the imagined nurses whose voices I wanted to hear and share, but it compounded my beliefs about my research incompetence.

This experience provided bait for my anxiety monster. I used the passengers on the bus metaphor⁷ (Hayes et al., 1999) as a means of defusing from the thoughts keeping me in an unhelpful stuck cycle of hopelessness. I noticed that the passengers were bullying me into powerlessness (Twohig et al., 2005). I had, in that moment, conceded to my anxiety, rather than taking measured risks (like trusting my supervisors) to move toward what matters.

⁷ This metaphor is typically used in ACT to support individuals to move from a position whereby they are subservient to their thoughts and feelings to a position whereby those thoughts and feelings can exist without dictating how that individual behaves. Importantly, the goal is not to reduce the frequency or intensity of the thoughts and feelings, but to encourage awareness and active engagement to make decisions about the relationship the individual has with their internal world and the choices they make, behaviourally, in respect of that relationship

By noticing this pitfall, I put myself in a powerful position, again, to make a choice to do something different. The passengers (my anxiety monsters) might still shout and threaten, but ultimately, I was the only person who could decide what route we took (Codd et al., 2011). Instead of fighting my frustrations, I could make room for them and accept that my reality was painful and, concurrently, channel my energy into doing something new and productive.

This involved meeting with new potential gatekeepers and scoping the potential for a new project with nurse educators and student mental health nurses. I was mindful not to perceive this as an exercise to gain more control, instead recognising the value of this process in getting back on track. I was inspired by the meetings I had, and the enthusiasm that my new project was generating amongst potential participants, and experts in the field (i.e. nurse educators). In line with ACT principles, being aware and in the present moment opened possibilities and encouraged a position of exploration and curiosity. I was conscious of the new time constraints of the project changing and was able to use this as a motivating spark to move forward rather ruminating and being self-defeating.

3.6. Moving forward: making committed actions

The process of overcoming the challenges that arose over the course of this research helped me to connect with what really matters to me: as a researcher, clinician, and individual. Whilst it makes intuitive sense, the realisation that these identities are not disparate – I am motivated by the same values whatever my role – provided useful scaffolding for my emerging researcher identity.

In my direct clinical work, this experience has helped me to become more self-aware when it comes to my passion for advocating for voices unheard. I am conscious of the potential for my own experiences to blur the reality of those I am attempting to illuminate. Instead, I have learnt that collaboration and curiosity underpin more authentic connections which allow for new realities, nuance, and contradictions to be shared. It is my role, as researcher and clinician, to facilitate this process – affording equal value, without judgement, to whatever emerges.

Generally, I have always been motivated to be ‘doing’, and this experience has evidenced how that drive can sometimes be counterproductive. I have learnt the value of taking time to pause. As a result, I have found that I work more efficiently. Similarly, I anticipate that my approach to MDT working in the future will change because of my experience with research. I am better able to shift between working independently (including appropriately persevering with challenges) and times when I need more support and guidance.

My researcher identity is by no means something I confidently ‘own’ now. However, this experience has been restorative: I am a capable researcher. A recurring theme when I have reflected on other experiences across training has been the paucity of research in various areas of clinical practice. My internal conflict about being a critical consumer of research without contributing to the research community is a motivating factor for engaging with my researcher identity in the future. In this respect, developing my researcher identity comes with, what feels like, an ethical obligation to use the tools I have developed to contribute to the emerging evidence

base in the areas I work and have clinical interest in. Continuing to live in line with my values, I endeavour to commit to the reciprocal roles of scientist-practitioner: protecting research within my job role as a qualified Clinical Psychologist. My first step in achieving this is to work with my supervisory team toward publication of the chapters presented in this thesis.

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APPENDICES

Appendix A. Authors' Instructions for *Journal of Emergency Nursing*

DESCRIPTION

The Journal of Emergency Nursing, the official journal of the Emergency Nurses Association (ENA), is committed to the dissemination of high quality, peer-reviewed manuscripts relevant to all areas of emergency nursing practice across the lifespan. Journal content includes clinical topics, integrative or systematic literature reviews, research, and practice improvement initiatives that provide emergency nurses globally with implications for translation of new knowledge into practice. The Journal also includes focused sections such as case studies, pharmacology/toxicology, injury prevention, trauma, triage, quality and safety, pediatrics and geriatrics. The Journal aims to mirror the goal of ENA to promote: community, governance and leadership, knowledge, quality and safety, and advocacy.

GUIDE FOR AUTHORS

Your Paper Your Way

We now differentiate between the requirements for new and revised submissions. You may choose to submit your manuscript as a single Word or PDF file to be used in the refereeing process. Only when your paper is at the revision stage, will you be requested to put your paper in to a 'correct format' for acceptance and provide the items required for the publication of your article. To find out more, please visit the Preparation section below.

Editorial Policies

The Journal of Emergency Nursing (JEN) welcomes unsolicited articles. Articles that are published as print articles in the JEN will also be published online in the correlating online issue of JEN. Articles that are designated by JEN as online-only will not be published in hardcopy, although they will be listed in the hardcopy table of contents. All JEN articles, print or online, are recognized as published articles. When an author is notified via email of the JEN issue to which his/her accepted article is assigned, he/she will also be notified whether his/her article will be published as online only or in hardcopy. All submitted manuscripts must be original material that has not been published elsewhere and is not under consideration by another journal at the time of submission to JEN. Required Permission for Copyrighted Materials It is the author's responsibility to obtain and submit proof of copyright permission for any material from previously published sources, including excerpted text, illustrations, charts, tables, photographs, etc. Proof of permission must be submitted along with the first revision in the form of a letter or document expressly granting permission for re-use of the material from the holder of the copyright. To determine whether a manuscript includes material(s) requiring copyright permission, authors are instructed to review the Elsevier Permissions Guidelines at the following link: <https://www.elsevier.com/about/policies/copyright/permissions>. The information at this site will provide details to assist the author in determining whether permission is required in her/his particular case, as well as simple instructions to follow in order to obtain permission should that be necessary.

Types of Papers

JEN publishes the following full-length and department articles. Submission information is provided below. Full-Length Articles: Research, Systematic Review, Meta-analysis, Practice Improvement, Clinical topics, and Clinical Science Translation Review. Department/Section Articles: Advanced Practice Spotlight, Case Review, Clinical Nurses Forum, Danger Zone, Geriatric Update, Images, Impressions, Injury Prevention, International Emergency Nursing, Nurse, Educator, Pediatric Update, Pharm/Tox Corner, Trauma Notebook, Triage Decisions, Understanding Research, and 'On the Other Side of the Rails' Blog. Letters to the Editor: JEN invites letters to the editor. While the focus of such letters can be a topic of special interest to the letter writer, all letters must be relevant to emergency nursing practice in order to be considered for publication. Most frequently letters are in response to a recent article published in JEN and provide additional information or discussion. Contact for Questions Direct questions to Managing Editor Annie Kelly at: anniewkelly@gmail.com or 413-427-3620.

Submission Information

All submitted manuscripts must be original material that has not been published elsewhere and is not under consideration by another journal at the time of submission to JEN. The review process customarily requires approximately 8 weeks, though there are exceptions. Enquiry calls or e-mails after 8 weeks to ask about the decision are welcomed. All new Research, Systematic Review, Integrative Review, Meta-analysis, Practice Improvement, Clinical, and Clinical Science Translation Review full-length manuscripts, as well as Case Reviews and Letters to the Editor, must be submitted through the JEN online submission and review Website (Editorial Manager). The Web site guides authors stepwise through the creation and uploading of the various files. Authors are to submit the text, tables, and artwork in electronic form to this address. Submission items include a cover letter, the manuscript (including title page, abstract [for research and practice improvement manuscripts only], main text with all text pages numbered, along with 'Continuous' line numbering, references, tables, figures, and table/figure legends, permission statement(s) for any copyrighted material [save as a separate file for upload], and electronic copy of the IRB permission letter when applicable [save as a separate file for upload].) Authors are responsible for statistical analysis, which must be reviewed for accuracy prior to article submission. Revised manuscripts should also be accompanied by a cover letter for comments to the editor. The submission order of files is as follows: cover letter, manuscript file(s), table(s), figure(s). Files are to be labeled with appropriate and descriptive file names (e.g., SmithText.doc, Fig1.eps, Table3.doc). Authors must submit their articles electronically to this journal at <https://www.editorialmanager.com/jen>. The system automatically converts source files to a single PDF file of the article, which is used in the peer-review process. All correspondence, including notification of the Editor's decision and requests for revision, takes place by via the Editorial Manager (EM) system.

NEW SUBMISSIONS

Submission to this journal proceeds totally online and you will be guided stepwise through the creation and uploading of your files. The system automatically converts your files to a single PDF file, which is used in the peer-review process. As part of the Your Paper Your Way service, you may choose to submit your manuscript as a single file to be used in the refereeing process. This can be a PDF file or a Word document, in any format or layout that can be used by referees to evaluate your manuscript. It should contain high enough quality figures for refereeing. If you prefer to do so, you may still provide all or some of the source files at the initial submission. Please note that individual figure files larger than 10 MB must be uploaded separately.

Preparation of Systematic Reviews, Integrative Reviews, and Meta-analysis

Authors may submit their manuscript (text, figures and tables) as a single file. This can be a Word or PDF file, in any format or layout, and figures and tables can be placed within the text. To facilitate double-blind review, author names and identifying information should be on the title page separate from the body of the text.

All text pages numbered, along with "Continuous" line numbering.

Figures should be of high enough quality for refereeing.

There are no strict formatting requirements but all manuscripts must contain the essential elements needed to evaluate a manuscript (Abstract, Keywords, Introduction, Materials and Methods, Results, Conclusions, Artwork and Tables with Captions).References can be in any style or format, as long as the style is consistent. Author(s) name(s), journal title/book title, article title (where required), year of publication, volume and issue/ book chapter and the pagination must be present. Use of DOI is highly encouraged. The reference style used by the journal will be applied to the accepted article by Elsevier at the proof stage.

When a paper reaches the revision stage, authors will be requested to deliver any items that are still required for publication, for example editable source files. Authors also are strongly encouraged to include the following on the initial submission to facilitate editor and reviewer evaluation for coherence with journal aims and scope:Contribution to Emergency Nursing Practice (3 bullet points described below),Implications for Emergency Nursing section between Discussion and Conclusions sections in body of text. Manuscripts that are Systematic Reviews, Integrative Reviews, and Meta-analysis are encouraged to begin with the heading "Contribution to Emergency Nursing Practice," followed by three bullet points using the format provided below. Limit this section to 120 words or less.

The current state of scientific knowledge on _____ [insert topic] indicates _____ . The main finding of this paper is _____. Key implications for

emergency nursing practice from this study are _____. The recommended length of the manuscript is 15 double-spaced pages, including all references, tables, charts, and figures.

If appropriate, an electronic copy of the Ethical Statement (also called the IRB permission letter) from the institution that granted permission to conduct the study is to accompany the first revision. If the Ethical Statement is not in English, an English translation must also be submitted. The Ethical Statement is to be uploaded to the "Ethical Statement" section of the manuscript in the EM submission system at <https://www.editorialmanager.com/jen>.

Authors are encouraged to use the PRISMA reporting guidelines (<http://www.equator-network.org/reporting-guidelines/prisma/>) to prepare the manuscript. Please be advised that while much of the content in the PRISMA Guidelines is appropriate for inclusion, every numbered subject headings (1-27) might not be applicable to every manuscript. References There are no strict requirements on reference formatting at submission. References can be in any style or format as long as the style is consistent. Where applicable, author(s) name(s), journal title/ book title, chapter title/article title, year of publication, volume number/book chapter and the article number or pagination must be present. Use of DOI is highly encouraged. The reference style used by the journal will be applied to the accepted article by Elsevier at the proof stage. Note that missing data will be highlighted at proof stage for the author to correct.

Appendix B. Coventry University Ethical Approval



Certificate of Ethical Approval

Applicant:

Alice Spiby

Project Title:

What are nurses' experiences of violence and aggression in emergency departments? A meta-ethnographic synthesis of the literature.

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as Low Risk

Date of approval:

01 November 2019

Project Reference Number:

P96792

Appendix C. Evidence of search strategy

CINAHL Database Search Strategy Example – Completed 25/11/2019



Monday, November 25, 2019 9:55:10 AM

#	Query	Limiters/Expanders	Last Run Via	Results
S1	("nurse" OR "qualified nurse" OR "general nurse")	Expanders - Apply equivalent subjects Search modes - Find all my search terms	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	222,465
S2	("violen*" OR "aggress*" OR "hostil*" OR "harass*" OR "assault*")	Expanders - Apply equivalent subjects Search modes - Find all my search terms	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	95,139
S3	("questionnaire*" OR "survey*" OR "interview*" OR "case stud*" OR "observ*")	Expanders - Apply equivalent subjects Search modes - Find all my search terms	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	921,749
S4	("view*" OR "experienc*" OR "opinion*" OR "attitude*" OR "percept*" OR "belie*")	Expanders - Apply equivalent subjects Search modes - Find all my search terms	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	837,980
S5	("qualitative" OR "mixed method*")	Expanders - Apply equivalent subjects Search modes - Find all my search terms	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	156,071
S6	S1 AND S2	Expanders - Apply equivalent subjects Search modes - Find all my search terms	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	4,800
S7	S3 OR S4	Expanders - Apply equivalent subjects Search modes - Find all my search terms	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	1,461,571
S8	S5 AND S7	Expanders - Apply equivalent subjects Search modes - Find all my search terms	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	131,769
S9	S6 AND S8	Expanders - Apply equivalent subjects Search modes - Find all my search terms	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	494
S10	S6 AND S8	Limiters - Published Date: 20020101-20191231 Expanders - Apply equivalent subjects Search modes - Find all my search terms	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	435
S11	S6 AND S8	Limiters - Published Date: 20020101-20191231 Expanders - Apply equivalent subjects Narrow by Language: - english Search modes - Find all my search terms	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - CINAHL	383

PsycINFO Database Search Strategy Example – Completed 25/11/2019

Ovid® Wolters Kluwer
My Account Ask A Librarian Support & Training  Help Feedback Logoff

Search Journals Books Multimedia My Workspace

▼ Search History (11) View Saved

<input type="checkbox"/> # ▲ Searches	Results	Type	Actions	Annotations
<input type="checkbox"/> 1 ("nurse" or "qualified nurse" or "general nurse").mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]	25444	Advanced	Display Results More ▼	 Contract
<input type="checkbox"/> 2 ("violent" or "aggress*" or "hostil*" or "harass*" or "assault*").mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]	200565	Advanced	Display Results More ▼	
<input type="checkbox"/> 3 ("questionnaire" or "survey*" or "interview*" or "case stud*" or "observ*").mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]	1172802	Advanced	Display Results More ▼	
<input type="checkbox"/> 4 ("view*" or "experienc*" or "opinion*" or "attitude*" or "percept*" or "belie*").mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]	1683236	Advanced	Display Results More ▼	
<input type="checkbox"/> 5 ("qualitative" or "mixed method*").mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh]	170721	Advanced	Display Results More ▼	
<input type="checkbox"/> 6 1 and 2	1044	Advanced	Display Results More ▼	
<input type="checkbox"/> 7 3 or 4	2338179	Advanced	Display Results More ▼	
<input type="checkbox"/> 8 5 and 7	142171	Advanced	Display Results More ▼	
<input type="checkbox"/> 9 6 and 8	130	Advanced	Display Results More ▼	
<input type="checkbox"/> 10 limit 9 to yr="2002 - 2019"	124	Advanced	Display Results More ▼	
<input type="checkbox"/> 11 limit 10 to english language	123	Advanced	Display Results More ▼	

Appendix D. Rationale for inclusion and exclusion criteria

The year of publication range was set to capture research published following a framework guideline from the WHO highlighting the challenge of workplace violence, specifically within healthcare (Di Martino, 2002). Articles were included if they were written in English.

In terms of participant inclusion criteria, the current review focused on the experience of general nurses. Student nurses, nursing auxiliaries and other sub-divisions of the qualified nursing population (for example Mental Health Nurses or Learning Disability Nurses) were excluded from the current review. In mixed sample papers specific data pertaining to the general nurse was eligible for inclusion where this could be isolated from the rest of the dataset. Specifically, this review focused on violence and aggression perpetrated toward nurses by patients, their family members, or visitors and did not include violence perpetrated by nurse-to-nurse or patient-to-patient.

As this is a meta-ethnography, qualitative and the qualitative arms of mixed-methods designs were appropriate for inclusion. This allowed for the integration of a “comprehensive understanding of participant experience” (Butler et al., 2016, p. 241).

Appendix E - Completed CASP Ratings R1 (researcher) R2 (colleague)

	Q1: Was there a clear statement of aims in the research?		Q2: Is a qualitative methodology appropriate?		Q3: Was the research design appropriate to address the aims of the research?		Q4: Was the recruitment strategy appropriate to the aims of the research?		Q5: Was the data collected in a way that addressed the research issue?		Q6: Has the relationship between the researcher and participants been adequately considered?		Q7: Have ethical issues been taken into consideration?		Q8: Was the data analysis sufficiently rigorous?		Q9: Is there a clear statement of findings?		Q10: How valuable is the research?		Total CASP Score (%)	
	R1	R2	R1	R2	R1	R2	R1	R2	R1	R2	R1	R2	R1	R2	R1	R2	R1	R2	R1	R2	R1	R2
Angland et al (2014)	2	2	2	2	1	1	2	2	2	2	0	0	2	2	2	2	2	2	2	2	17	17
Christie (2015)	2	2	2	2	2	2	2	2	2	2	0	0	2	2	2	2	2	2	2	2	18	18
Gillespie et al (2013)	2	2	2	2	1	1	2	2	2	2	0	0	2	2	2	2	2	2	2	2	17	17
Han et al (2017)	2	2	2	2	2	2	1	1	2	2	2	2	2	2	2	2	2	2	2	2	19	19
Hassankhani et al (2018)	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	20	20
Hislop et al (2003)	2	2	2	2	2	2	2	2	2	2	2	2	2	1	1	1	2	2	2	2	19	18
Howerton Child & Sussman (2017)	2	2	2	2	2	2	2	2	2	2	0	0	2	2	2	2	2	2	2	2	18	18
Hyland et al (2016)	2	2	2	2	2	2	2	2	2	2	1	0	2	2	2	2	2	2	2	2	19	18
Lau et al (2012)	2	2	2	2	2	2	2	1	2	2	0	0	2	2	1	1	2	2	2	2	17	16
Luck et al (2012)	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	20	20

	Q1: Was there a clear statement of aims in the research?		Q2: Is a qualitative methodology appropriate?		Q3: Was the research design appropriate to address the aims of the research?		Q4: Was the recruitment strategy appropriate to the aims of the research?		Q5: Was the data collected in a way that addressed the research issue?		Q6: Has the relationship between the researcher and participants been adequately considered?		Q7: Have ethical issues been taken into consideration?		Q8: Was the data analysis sufficiently rigorous?		Q9: Is there a clear statement of findings?		Q10: How valuable is the research?		Total CASP Score (%)	
	R1	R2	R1	R2	R1	R2	R1	R2	R1	R2	R1	R2	R1	R2	R1	R2	R1	R2	R1	R2	R1	R2
Pich et al (2011)	2	2	2	2	2	2	2	2	2	2	1	0	2	2	1	0	2	2	2	2	18	16
Pich et al (2013)	2	2	2	2	2	2	2	2	2	2	1	0	2	2	2	2	2	2	2	2	19	18
Ramacciati et al (2015)	2	2	2	2	1	1	2	2	2	2	2	2	2	2	2	2	2	2	2	2	19	19
Ramacciati et al (2018)	2	2	2	2	1	1	2	2	2	2	2	2	2	2	2	2	2	2	2	2	19	19
Tan et al (2015)	2	2	2	2	0	0	2	1	2	2	1	1	2	2	2	2	2	2	2	2	17	16
Wolf et al (2014)	2	2	2	2	2	1	2	2	1	1	0	0	2	2	1	1	2	2	2	2	16	15
Wright-Brown et al (2016)	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	20	20

Reasons for scores of 1 or 0:

Angland et al (2014)

Q3: The justification for the research design is unclear

Q6: No discussion concerning the relationship between researcher and participant is reported

Christie (2015)

Q6: No discussion concerning the relationship between researcher and participant is reported

Gillespie et al (2013)

Q3: The justification for the research design is unclear

Q6: No discussion concerning the relationship between researcher and participant is reported

Han et al (2017)

Q4: Limited information reported on how recruitment was facilitated

Hislop et al (2003)

Q8: The process of analysis was not discussed in depth

Howerton Child & Sussman (2017)

Q6: No discussion concerning the relationship between researcher and participant is reported

Hyland et al (2016)

Q6: The relationship between researcher and participant was considered to some degree by use of a pilot project to enhance appropriateness and accessibility of the survey

Lau et al (2012)

Q6: No discussion concerning the relationship between researcher and participant is reported

Q8: Limited discussion of what the analysis process entailed (reported in more detail in a partner paper)

Pich et al (2011)

Q6: The relationship between researcher and participant is reported as participants verifying the accuracy of the findings

Q8: Discussion of the analysis process is brief

Pich et al (2013)

Q6: The relationship between researcher and participant is not considered beyond participants verifying the accuracy of their transcript

Ramacciati et al (2015)

Q3: The justification for the research design is unclear

Ramacciati et al (2018)

Q3: The justification for the research design is unclear

Tan et al (2015)

Q3: No justification for the research design is given

Q6: The relationship between the researcher and participant is partly considered in terms of the time and location of interview being mutually convenient

Wolf et al (2014)

Q5: Limited information regarding the data collection process is given

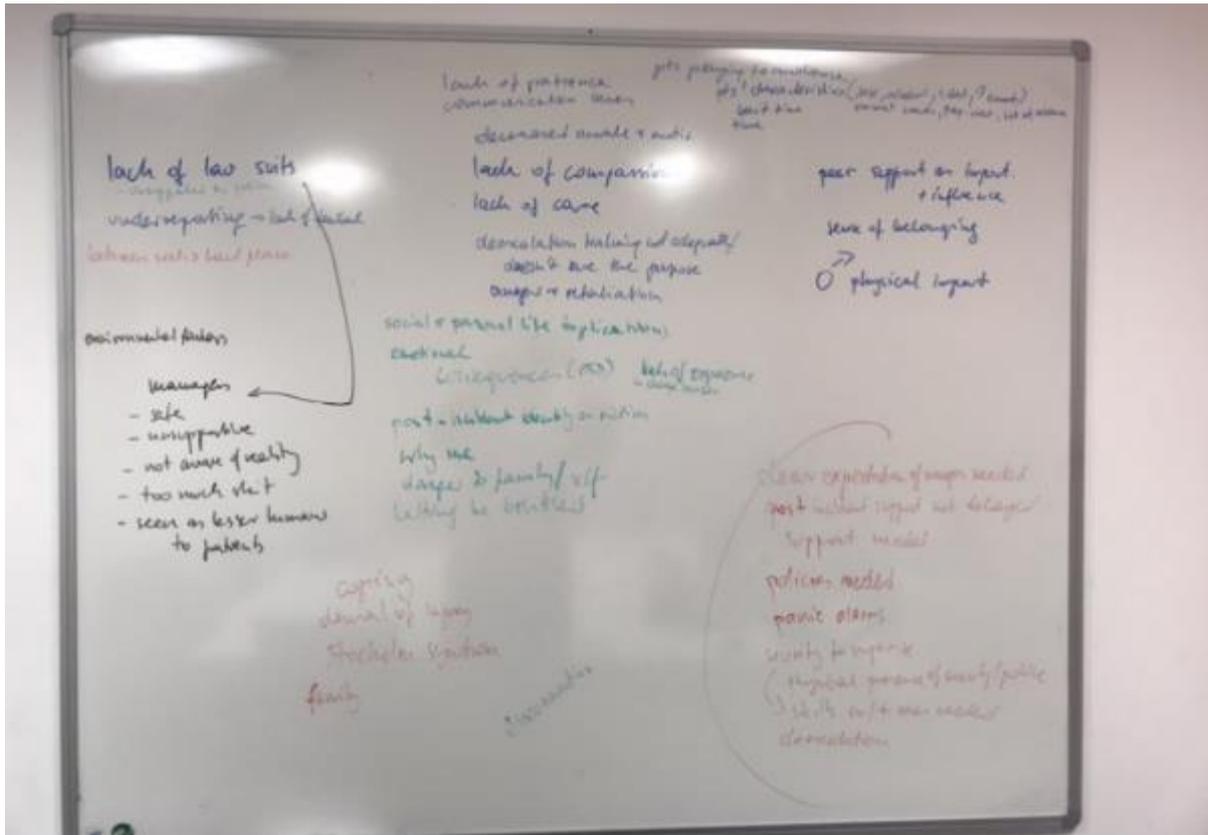
Q6: No discussion concerning the relationship between researcher and participant is reported

Q8: Discussion of the process of analysis is brief

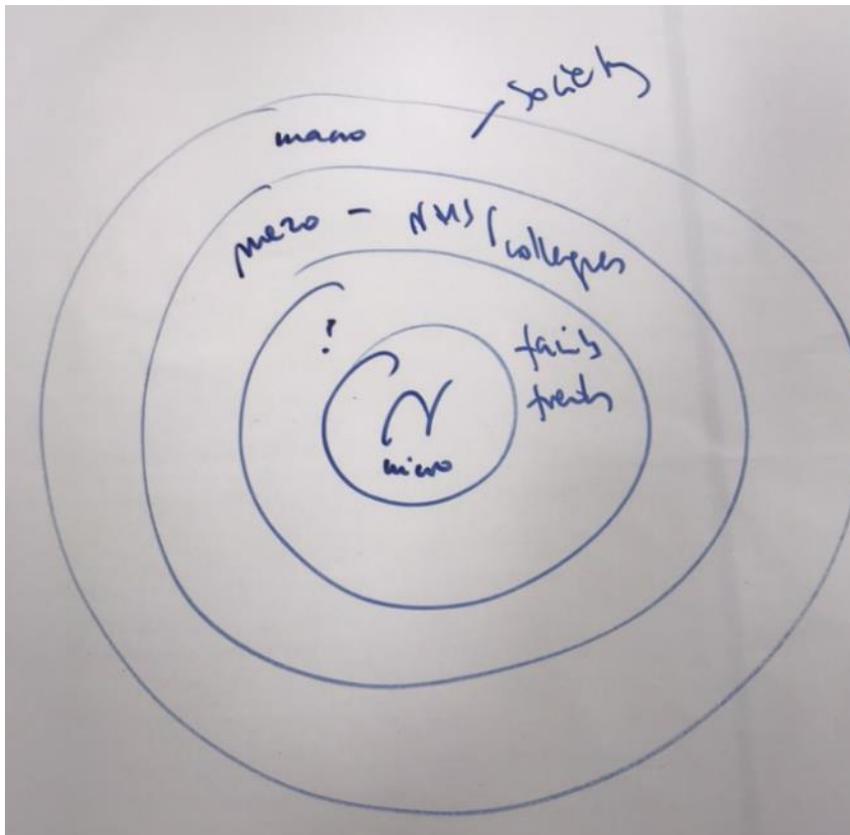
Appendix F. Evidence of analysis process

<p style="text-align: center;">Environment</p> <ul style="list-style-type: none"> • small rooms leaving staff trapped • lack of or limited access to security • lack of experienced security staff to diffuse problems • overcrowded conditions (e.g. beds in corridor) • lack of communication • miscommunication between staff <p>A</p> <ul style="list-style-type: none"> • security staff (experienced) • panic buttons 	<p style="text-align: center;">Patients</p> <ul style="list-style-type: none"> - in their own world - unaware of entry - everything needs to be done away - not given the privacy they expect - being told I don't, expecting it but the left hand didn't know what the right hand was doing - we agreeable to alleviate frustration done or propose 			
<p>Angland, Dowling, & Casey (2014)</p> <p>Results</p> <p>At the start of the interview, each participant was asked to explain what they understood by the term 'violence and aggression'. The participants were able to clearly distinguish between violence and aggression throughout all the interviews.</p> <p>All the nurses described aggression as a verbal non-physical act sometimes with a threat of violence.</p> <p>N3: "Aggression I would define... as where somebody would use language or body language that you could deem to be threatening or that may have a hint of violence behind it without being physically violent."</p> <p>N2: "Aggression I suppose... is more verbal rather than an actual physical act, or that you feel in some way threatened that violence may occur towards you."</p> <p>In contrast, violence was viewed as a physical act where the individual might punch or spit resulting in an injury to the person.</p> <p>N1: "Violence I think is when some one strikes out at you, not necessarily with their hand and foot but even if they spit at you, I consider that violent."</p> <p>N8: "Violence then would be the actual physical, the physical harm caused by it a hit or punch or throwing of an object."</p> <p>During the interviews it became evident that the above definitions were reflected in the encounters of aggressive or violent incidents recalled by participants.</p> <p>Environmental factors</p> <p>A variety of environmental factors that cause violence and aggression in the ED were highlighted, including long waiting times, lack of space and overcrowding, triage and security.</p> <p>All but one participant talked about waiting times being one of the greatest causes of violence and aggression in the ED. The long waiting times mentioned specifically related to patients waiting to see a doctor or to get a bed on a ward. Most participants reported the difficulties they had with this, especially when relatives' families engaged in persistent</p> <p style="text-align: right;">family influence ↓ risk related factors?</p>	<p style="text-align: center;">Division between</p> <table style="width: 100%; border: none;"> <tr> <td style="text-align: center; vertical-align: top;"> <p>aggression</p> <p>↓</p> <ul style="list-style-type: none"> - verbal language / body language of threatening nature </td> <td style="text-align: center; vertical-align: top;"> <p>or</p> </td> <td style="text-align: center; vertical-align: top;"> <p>violence</p> <p>↓</p> <ul style="list-style-type: none"> - physical contact - possibly personal boundaries </td> </tr> </table> <p style="text-align: center;">Staffing exposure of A+E</p> <ul style="list-style-type: none"> - lack of time - lack of resources - under pressure & stress - lack of patience - variability especially difficulties → in a state of high alert - feeling vulnerable / at fault / trapped / responsible / help - none 	<p>aggression</p> <p>↓</p> <ul style="list-style-type: none"> - verbal language / body language of threatening nature 	<p>or</p>	<p>violence</p> <p>↓</p> <ul style="list-style-type: none"> - physical contact - possibly personal boundaries
<p>aggression</p> <p>↓</p> <ul style="list-style-type: none"> - verbal language / body language of threatening nature 	<p>or</p>	<p>violence</p> <p>↓</p> <ul style="list-style-type: none"> - physical contact - possibly personal boundaries 		

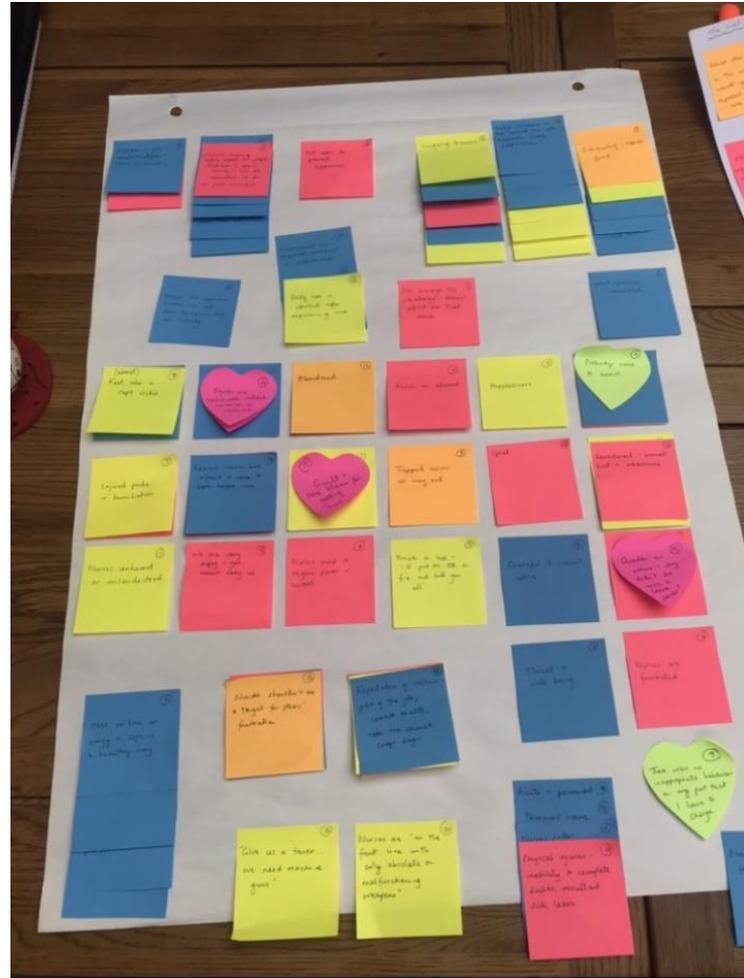
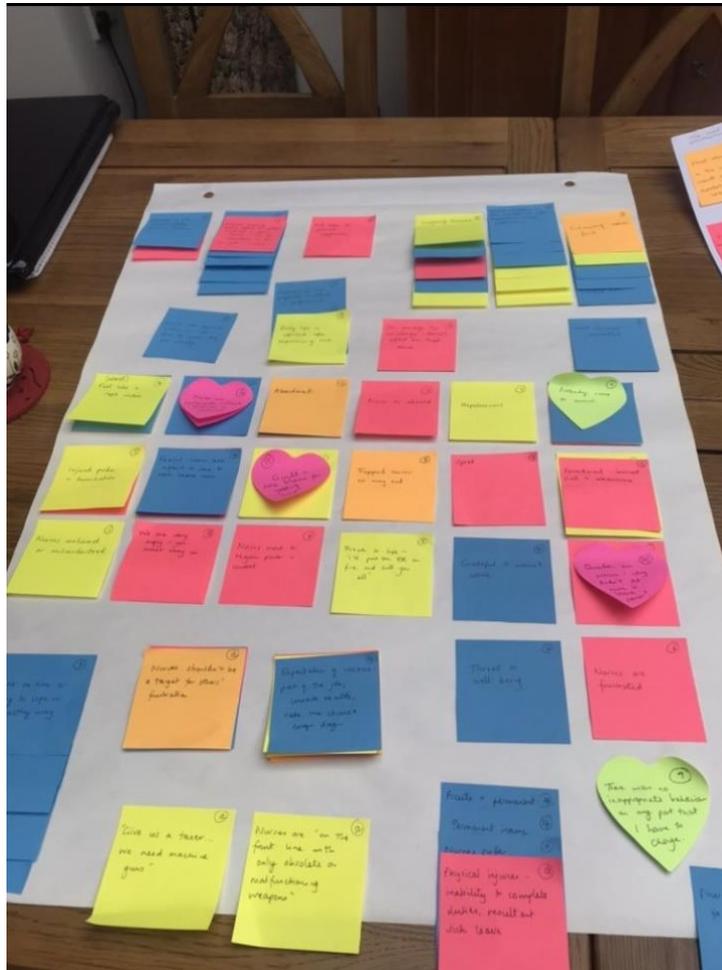
Co-coding of Angland et al. (2014).



Discussion and initial mapping of meta-themes and sub-themes



Modelling of the themes on Bronfenbrenner's (1979) ecological model



Arrangement of codes into themes

Appendix G. Further examples of direct quotations from original papers to illustrate sub-themes

Meta-theme: Violence in the ED

Sub-theme: Violence and aggression faced by nurses in the ED

- “Violence I think is when some one strikes out at you, not necessarily with their hand or foot but even if they spit at you, I consider that violent” (Angland et al., 2014, p.136)
- “An aggressive act would not be regarded as violence if the: (1) patient was not considered responsible for his or her action, or (2) a nurse involved in the violent incident thought that he or she was not a target (e.g. ‘... not directed at me’)” (Lau et al., 2012, p.128)
- “violence was unpredictable and inevitable” (Lau et al., 2012, p.129)
- “The patients’ diagnosis and presenting or comorbid health problem was frequently identified by participants as being a mitigating factor especially if the agent of violence was confused or disorientated to time, place, person or event secondary to health problems” (Luck et al., 2008, p.1075).
- “Participants reported being confronted with both conventional and opportunistic weapons... ‘someone had got a hold of a sharps bin and had taken needles out of the sharps bin and was threatening staff with the needles’ (participant 5)”. (Pich et al., 2011, p.14)
- “Yes, threatening – I have been escorted to my car a few times by security because I was just a bit nervous” (Pich et al., 2011, p.14)
- “‘... he was threatening to kill me’ (P7)...” (Pich et al., 2013, p.159)
- “Violence against you as a person, as a citizen and as a professional” (Ramacciati et al., 2015, p.277)
- “Participants discussed the use of both traditional weapons and opportunistic items as weapons to intimidate and threaten staff... ‘...grabbed a pole and came back and smashed the window down trying to kill her...’ (P7)...” (Pich et al., 2013, p.159)
- “It’s psychological violence when you feel vulnerable and there’s no-one to defend you” (Ramacciati et al., 2015, p.277)

- “One patient said “you don’t let me see you outside the hospital. I’ll kill you oif I see you”. So because of this case, we made a police report because it is (a) a threat and you won’t know if he really will come back and kill you, because he can just wait outside for you in (this hospital), then... follow you home” (Tan et al., 2015, p.310)

Sub-theme: Social complacency and the law

- “lack of understanding on the part of the public regarding the current ED crisis in Irish hospitals” (Angland et al., 2014, p.136)
- “the police [could press charges] if they wanted; if it really got to it, but it’s a lot of paperwork. I’m not sure they would be willing to put the time and effort into it” (Christie, 2015, p.34)
- “as far as suing patients, our superiors and the hospital only try and talk to us... how much time would it take to actually conduct a lawsuit? We haven’t received any satisfactory results from any cases thus far; if we don’t have any expectations, then we won’t feel let down” (Han et al., 2017, p.431)
- “The disparaging thing about it is that you feel in all these forms and you don’t see the repercussions of it – you never actually get any feedback from it. You might fill them in more if you felt you were getting positive feedback from it” (Hislop et al., 2003, p.9)
- “A confused elderly patient ho spat at a nurse was not considered to be violent. The same behaviour from a young patient under the influence of alcohol was considered to be violence... such an understanding of cultural meaning of violence is important for the construction of measures looking at reporting violent incidents” (Lau et al., 2012, p.128)
- “I’ll take a big of a slap from an old lady but if the guy next door is drunk and he slaps me, I’m not doing to put up with that and that’s a judgement right there” (Luck et al., 2008, p.1074).
- “... the internet age... they want it faster and they don’t want to wait – and unfortunately our system at the moment is not designed around rapid delivery” (Pich et al., 2013, p.159)

- “This did not extend to actual charges being laid by police punishment ‘... they’re allowed to get away with it... I think that’s one of the frustrations with where we work” (Pich et al., 2013, p.160)
- “The law prevents us from reacting because even if you are just trying to defend yourself, you are suddenly in the wrong, so we just have to stand and take it (Ramacciati et al., 2015, p.277)
- “There are pathological situations, like the old lady who gets mad and kicks: how can you call that violence? That’s more like psychiatric cases or drunks: it’s not deliberate violence, it’s part of the person’s illness” (Ramacciati et al., 2015, p.277)
- “We all experience verbal abuse sooner or later, especially the triage nurses. In this environment I think we begin to perceive such episodes as disagreeable but not really important, and so we don’t report them unless they are exceptionally serious” (Ramacciati et al., 2018, p.23)
- “Nurses are not as respected as doctors. Patients, relatives and visitors feel free to behave very badly with the nursing staff” (Ramacciati et al., 2018, p.24)
- “The episodes of verbal and physical violence that nursing staff have to undergo every day are due to bad manners, bad behaviour and lack of respect for regulations and other people’s work.” (Ramacciati et al., 2018, p.24)
- “violence was a: ‘growing social phenomenon, because of sociopathy”” (Ramacciati et al., 2018, p.24)
- “The obvious solution, appears to be the hardest to implement because clearly it is all down to the politics of austerity and outrageous cutting healthcare costs” (Ramacciati et al., 2018, p.26)
- “I called (the police) to come and help me because it is a very violent patient in the department. So after taking down my report... they asked me, “Do I want to pursue the matter?”... and I was thinking... why am I given a choice to pursue this matter? Can’t they choose to pursue them instead of me charging him for doing all these violence and vulgarities? Because if I pursue this matter, they told me, it is under civil law and I sue him accordingly” (Tan et al., 2015, p.309)

- “I received a call from the district attorney’s office some months later and was informed that I could pursue charges but likely there would be no penalty or “sentencing” related to the charges so I elected not to pursue it further” (Wolf et al., 2014, p.307)
- “A judge said to a nurse (participant C), “[W]ell isn’t that the nature of the beast, being in the emergency room and all?” Participant C said, “Gosh... I almost feel like a rape victim in court...” (Wolf et al., 2014, p.307)
- “In one situation, the perpetrator was arrested but for the earlier charge of resisting arrest, not for the injury to the Registered Nurse” (Wright-Brown et al., 2016, p.195)
- “Still a lack of prosecution... it’s just easier for them to stay out of it” (Wright-Brown et al., 2016, p.195)
- “Police wouldn’t do anything that night” (Wright-Brown et al., 2016, p.195)
- “they have policies against violence but nothing happened when the violence occurred” (Wright-Brown et al., 2016, p.195)

Meta-theme: Nobody cares, nothing changes

Sub-theme: The media: nurses lynched

- “parents often used information gained from the media or the internet to pre-diagnose their child... If this information was at odds with that given by the triage nurse and their child was given a low priority in terms of triage, there was a potential for conflict” (Pich et al., 2013, 160)
- “violence is usually caused by distrust of, and contempt for healthcare staff, particularly for public hospitals and episodes of medical malpractice. Press reports encourage these feelings” (Ramacciati et al., 2018, p.24)
- “They never talk about our success stories – only medical malpractice and our mistakes. We hear good news at times about the police or the fire-fighters, but never about us” (Ramacciati et al., 2018, p.26)

Sub-theme: Management: “See my bruising”

- “management... everyone, emphasises patient rights, family-centred care... but we don’t have to be victims for that to happen” (Christie, 2015, p.34).

- “Wanted managers to be aware that ‘we have rights as human beings to be protected physically, we have a right not to be abused” (Christie, 2015, p.34)
- “Some managers will just give the patient whatever they want so they’re happy, and some will stick up for the nurses. I’m not really sure which one is better, actually” (Howerton Child & Sussman, 2017, p.549).
- “When you ask for management, you also have to ask yourself, what do you expect them to do? Kick the patient out? Yell back at the visitor? Yeah, clear expectations is needed or everyone is frustrated” (Howerton Child & Sussman, 2017, p.549)
- “The impact of workplace violence as underestimated and undervalued particularly by healthcare managers... ‘it is a real problem which is getting worse all the time. It is ignored by management who should ensure the workplace is safe for health personnel” (Ramacciati et al., 2018, p.25)
- “Management underestimates workplace violence despite recommendations from the Ministry of Health” (Ramacciati et al., 2018, p.25)
- “The perpetrator gets away with it because management listens to them and takes their side” (Ramacciati et al., 2018, p.26)
- “Frustration over an episode of violence is usually made worse because management tends to blame the nurse and rarely takes any action against the perpetrators” (Ramacciati et al., 2018, p.26)
- “Nurse managers did not show concern or render support” (Tan et al., 2015, p.309)
- “Management rarely acted on reports or provided additional resources to support nurses in managing aggressive incidents” (Tan et al., 2015, p.310)
- “[A]dministration will only take action when some lethal event happens” (Wolf et al., 2014, p.307)
- “[The Chief Nursing Officer] seemed to be more concerned that I was filing a police report than over the fact that I was assaulted” (Wolf et al., 2014, p.307)
- “Nobody cares, nothing changes” (Wolf et al., 2014, p.306)
- “The respondents all expressed a level of dissatisfaction with the corporate response to violence in their facility” (Wright-Brown et al., 2016, p.195)

Sub-theme: Environmental factors

- “triage is the worst place to work, it’s never ending out there” (Angland et al., 2014, p.136)
- “...the area in triage did not allow for an ‘out’...” (Gillespie et al., 2013, p.5)
- “Our facility has no ‘surveillance’ or rooms where you can see in. It is very uncomfortable to walk in a room and not know what to expect” (Gillespie et al., 2013, p.5)
- “It starts in triage and continues all the way through. Because you try to manage the people who are in the waiting room, who don’t want to be in the waiting room, and they see other people go in ahead of them and they are infuriated and they don’t understand the concept of triage” (Howerton Child & Sussman, 2017, p.549)
- “... more challenging on night shifts with less help” (Hyland et al., 2016, p.147).
- “dissatisfaction associated with waiting times was perceived as a crucial trigger for violence... the waiting time shown in the waiting room was subject to triage nurses or clerks’ availability to update the system” (Lau et al., 2012, p.130)
- “... ‘us versus them’. Firstly in relation to the triage nurses versus the waiting room with the waiting room perceived as an entity or audience” (Pich et al., 2011, p.15)
- “comments about the participants and other nurses were often made directly to the waiting room with perpetrators looking for a reaction be it positive or negative... these behaviours were considered to be exacerbated by long waiting times both actual and perceived” (Pich et al., 2013, p.159)
- “patients and relatives are already irritated by the idea of having to wait a long time” (Ramacciati et al., 2018, p.24)
- “‘the nurse is always in danger’ especially in triage: ‘... we’re even more exposed in triage as we work alone’” (Ramacciati et al., 2018, p.26)
- “Participants described unsafe work environments, where safety measures were put into place (e.g. security cameras or panic buttons) but were not maintained.” (Wolf et al., 2014, p.307)

- “One nurse described posted signs placed after her assault that were not enforced... I finally asked if we were ever going to act on these signs and I was told that basically they were just up for show” (Wolf et al., 2014, p.307)
- “... difficult to work in triage where the nurse worked alone, in a location where she is unseen” (Wolf et al., 2014, p.307)
- “Lack of institutional recognition of the high-risk patient, leaving the nurse in a vulnerable position” (Wolf et al., 2014, p.308)

Sub-theme: Patient implications: “Don’t care if they live or die”

- “a lot of the time you might be stressed, you might aggravate the situation because you haven’t got time or the interest to deal with certain patients that shouldn’t be there anyway” (Angland et al., 2014, p.137)
- “I’ll let my work standards sink very low when caring for such violent patients or dealing with violent family members” (Han et al., 2017, p.432)
- “When I run into such violent patients, I don’t really care if they live or die – I just want to get them out of there.” (Han et al., 2017, p.433)
- “I feel very frustrated and angry, wanting to probably be able to retaliate” (Hislop et al., 2003, p.8)
- “They expect you to be that doting person to them after they rip you apart verbally. It’s fascinating... I don’t know what other place in the world where they expect someone to take care of them and yet they can destroy you verbally and sometimes try to attack you physically, and then they expect you to take care of them” (Howerton Child & Sussman, 2017, p.548).
- “It is hard to be empathetic when someone is abusing you using the F words” (Pich et al., 2011, p.15)
- “they end up getting seen sooner to stop the ruckus going on” (Pich et al., 2013, p.159)
- “they get the attention purely because it’s unsafe for them to be out in the waiting room” (Pich et al., 2013, p.159)
- “your attention risks being distracted from the patient. Especially during triage when you are constantly interrupted while assigning priority codes” (Ramacciati et al., 2018, p.26)

- “I was punched... it was quite painful. So I kept thinking what can I do better? Why must I go and attend to that patient? Sometimes I feel like I should just ignore that person” (Tan et al., 2015, p.308)
- “As a result of physical injuries sustained, nurses were not always able to complete their nursing duties and were required to take sick leave” (Tan et al., 2015, p.308)
- “Of course, at the scene, we are very angry... We... shout at the patient” (Tan et al., 2015, p.309)

Meta-theme: Peers and perpetrators

Sub-theme: Peers: We are family

- “Peers ‘had their back’ no matter what” (Christie, 2015, p.34)
- “Outside the department, no one seems to understand what it’s really like but your colleagues do” (Hislop et al., 2003, p.9)
- “we have a couple of nurses who just stand up, you know, for the weaker nurses who can get picked on by certain patients. They will step in and take over the assignment or whatever that can do to help but in a positive way” (Howerton Child & Sussman, 2017, p.549)
- “We usually rely on us bigger males to take care of the problem patients. When none of us (guys) are working sometimes things get more out of hand, the female nurses have said. Maybe patients go from mouthing off to being physical if they don’t think anyone is around to do anything about it” (Howerton Child & Sussman, 2017, p.549).
- “all participants reported informal debriefing with other staff members as being their main coping mechanism” (Pich et al., 2011, p.16)
- “in my case, my coordinator openly defended me, in front of me, and I felt really supported by that, it had a healing effect at the time” (Ramacciati et al., 2015, p.277)
- “[violent acts] may be triggered by the nurses themselves if they display a hostile attitude towards patients and visitors” (Ramacciati et al., 2018, p.23)
- “Most nurses sought support from colleagues – “counselling each other” – to cope with the emotional effects” (Tan et al., 2015, p.309)

- “Another nurse in the ER [emergency room] gave me a hard time and said if I “couldn’t handle it, I should get out of emergency medicine” (Wolf et al., 2014, p.308)
- “We take care of each other” (Wright-Brown et al., 2016, p.195)
- “Respondents reflected statements indicating a connection and some level of reliance on their colleagues” (Wright-Brown et al., 2016, p.195)

Sub-theme: The perpetrators

- “I’d like to allay the myth that it’s always drugs and substance abuse that causes aggression... That’s actually far from the truth... this guy wasn’t drunk... he knew what he was saying and he was just trying to be as insulting as possible without actually being physical” (Angland et al., 2014, p.137)
- “patients in police custody, history of violence, frequent user of the ED and patient death” (Gillespie et al., 2013, p.5)
- “Once I was taking care of a drunk patient, then his friend came to the ER. I asked the security guard to guide him out. He pushed me away, I fell and broke my leg” (Hassankhani et al., 2018, p.22).
- “They walk all over you and treat you like dirt and that makes me feel frustrated and powerless” (Hislop et al., 2003, p.8)
- “They are not prepared to sit back and wait for their fellow man who is much more seriously injured to be treated” (Hislop et al., 2003, p.8)
- “patient / relative factors were considered to be the sole cause of violence in particular for patient/relative who had drug/alcohol or psychiatric problems” (Lau et al., 2012, p.129)
- “I find the women are a lot more demanding now when they are drinking and we get a lot more fights now with the women” (Pich et al., 2011, p.15)
- “Unkempt, tattooed... people from lower socioeconomic groupings” (Pich et al., 2011, p.15)
- “under the influence of alcohol, and/ or illicit drugs” (Pich et al., 2013, p.159)
- “I already know that this patient tends to be aggressive, because they already have a history, or I have already seen them being aggressive... we have regular patients, drunk patients, who regularly turn up in our department” (Tan et al., 2015, p.309)

Meta-theme: “on the front line with only... malfunctioning weapons”

Sub-theme: I am a nurse: it’s “in our work contract”

- “tolerated large amounts of abuse from patients and relatives because it was believed to be part of the job” (Angland et al., 2014, p.137)
- “at what point does a patient’s right (for care) trump my right to feel safe?” (Christie, 2015, p.34)
- “The patient dumped the contents of his box lunch on me... All I could do was count myself lucky that he hadn’t poured hot coffee or soup on me, and burn me. After I changed my soiled clothing I still had to perform all my remaining duties”. (Han et al., 2017, p.431).
- “Part of the job” (Han et al., 2017, p.433)
- “I really really don’t think that when you are there in a caring capacity and you are there to help people – I don’t think we need to take or should be expected to take that abuse” (Hislop et al., 2003, p.8)
- “this isn’t how I thought being an ED nurse would be” (Howerton Child & Sussman, 2017, p.548)
- “Violence that was directed towards a nurse as a symbol of the ‘system’ did not impact negatively on the emotional well-being of the participants” (Luck et al., 2008, p.1074)
- “You know, losing something. Whether it’s loss of privacy, loss of control, its all that... self-preservation and um you can do as much as you can to help the patient to have that self-preservation then you’re, I’d say more than 90% of the way there, um there’s some things that are just out of control that none of us can control like a death, you know, if it’s inevitable we just have to deal with the aftermath of the situation but yeah, as I said I don’t feel threatened, I’m not emotionally drained by the violence” (Luck et al., 2008, p.1075).
- “... most of it I don’t take it on board personally because it’s not directed at me, Wendy, it’s directed at the person who happens to be standing in front of that drunk person or that drugged person and I can appreciate that” (Luck et al., 2008, p.1075)
- “This is not suggesting that the participants accepted violence as part of the job, rather the meaning assigned to violence was both contextualised and

reconstructed as part of the agent of the violence, or characteristics of the patient, their family and friends based on perceived mitigating factors” (Luck et al., 2008, p.1076)

- “I find they are completely different people to the medical officer than to the nursing staff” (Pich et al., 2011, p.14)
- “I turn up to try and help them with the limited resources that we have got and I don’t know – people are a little ungrateful and I get disheartened by it” (Pich et al., 2011, p.15)
- “All participants reluctantly reported a sense of inevitability with regards to patient-related violence in their working lives” (Pich et al., 2011, p.15)
- “there is an expectation that we should be able to hack it” (Pich et al., 2011, p.16)
- “sadly I put it down as part of the job” (Pich et al., 2013, p.160)
- “It’s part of the game (...) in the Triage area it really seems to be the norm, it just seems like an inevitable part of the situation, as if we just can’t avoid it and I’m constantly aware of the nurses’ uneasiness” (Ramacciati et al., 2015, p.277)
- “I feel I have a right not to be pushed when I am working but you do feel like saying it’s nothing much because you’re right, we take it for granted, I take it for granted and I am the newest member of staff” (Ramacciati et al., 2015, p.277)
- “we get used to it... that’s not a professional statement but it’s the most honest” (Ramacciati et al., 2018, p.23)
- “We are the scapegoats for everyone’s bad moods. Nobody protects us. Every day we have to struggle against bad manners and arrogance and our reward is more insults” (Ramacciati et al., 2018, p.24)
- “It has become just the individual nurse’s own problem” (Ramacciati et al., 2018, p.26)
- “It’s as if verbal violence was a clause in our work contract!” (Ramacciati et al., 2018, p.26)
- “we all know this is the chance we take every day in our job as ED nurses” (Wolf et al., 2014, p.308)

- “You know there was a patient – somebody who needed help and I never thought about it... I just went there” (Wright-Brown et al., 2016, p.195)

Sub-theme: I am a person with “lingering trauma”

- “My mind went truly blank during the incident, and afterward I wondered whether my life could have ended then and there” (Han et al., 2017, p.431)
- “I didn’t dare go out for a period of time after I was attacked. For a while after it happened, whenever I walked along the road where the hospital is located, the memory of being hit always came to mind” (Han et al., 2017, p.432).
- “direct threat to life” (Han et al., 2017, p.432)
- “Facing violence has affected my morale for a long time. Working in the emergency room is depressing because of the unpleasant events you see and the violence you face. I am on antidepressant medication for several years now” (Hassankhani et al., 2018, p.22)
- “Why me?” (Hislop et al., 2003, p.8)
- “it is exhausting” (Howerton Child & Sussman, 2017, p.549)
- “After you’ve seen your 40th patient of the day, and your nerves are fried, sometimes that wins out, and you go back to your reactive self” (Howerton Child & Sussman, 2017, p.550)
- “When somebody attacks you personally – your appearance, your manner whatever even though you know that it shouldn’t affect you, it does at some level. Sort of, you know, feel awful” (Luck et al., 2008, p.1074)
- “I’m scared not just for myself but for the other people around me and I’m scared of the impression the child is getting... about what might be normal” (Pich et al., 2013, p.160)
- “I felt wounded” (Ramacciati et al., 2015, p.277)
- “These things, of course, they leave a mark on you” (Ramacciati et al., 2015, p.277)
- “I was scared, scared, scared. Of course if someone shouts at me in the Triage area, it’s irritating and upsetting but being really scared is another thing altogether” (Ramacciati et al., 2015, p.277)
- “It makes us depressed, burned out and demotivated” (Ramacciati et al., 2018, p.26)

- “Lingering psychological trauma... ‘I have never been afraid to come to work before but now I find myself fearful and reluctant to come in to a violent situation’” (Wolf et al., 2014, p.307)
- “For some reason this triggered a post traumatic reaction for me. I instantly became very shaky, nauseated and started crying... I then went to counselling for a couple of months, I think. My biggest hurdle... was [that I felt], and I still do, feel like a victim, rather than getting to be in the ‘superman’ role” (Wolf et al., 2014, p.307)

Sub-theme: My future

- “The mere presence of security acted as a deterrent and reduced incidents of violence or aggression” (Angland et al., 2014, p.136)
- “Management should make it ‘mandatory for anyone who experiences violence to see counsellors within a week’” (Christie, 2015, p.34)
- “security devices were only implemented in one ED after a severe act of physical violence” (Gillespie et al, 2013, p.5)
- “having real security guards would help, not the one who is 90 pounds soaking wet. Or the guy who you can hear him breathe from across the room... having real law enforcement with badges and armed weapons: just the face value. People don’t usually act out when they see that” (Howerton Child & Sussman, 2017, p.549)
- “Need own security every evening / night that would be available to supervise patients and prevent incident/escalation” (Hyland et al., 2016, p.146)
- “one of our demands... is for an examination of the possibility for the legal department to offer the staff advice” (Ramacciati et al., 2015, p.277)
- “we need specific training for these episodes which we don’t get from our Health Board” (Ramacciati et al., 2018, p.26)
- “I suggest we need a 24-h police service for staff safety” (Ramacciati et al., 2018, p.26)
- “Give us a Taser!” (Ramacciati et al., 2018, p.26)
- “more nursing and auxiliary staff + better facilities + shifts with lower workload = less violence” (Ramacciati et al., 2018, p.26)

- “I need the help of my senior nurses to teach me... how to properly manage (aggressive patients) or how to decide what interventions to use (in aggression management)” (Tan et al., 2015, p.310)

Appendix H. Authors' instructions for *Journal of Psychiatric and Mental Health Nursing*

1. SUBMISSION

Thank you for your interest in the *Journal of Psychiatric and Mental Health Nursing*. Note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

Once you have prepared your submission in accordance with the Guidelines, manuscripts should be submitted online at <https://mc.manuscriptcentral.com/jpm>

The submission system will prompt you to use an ORCID iD (a unique author identifier) to help distinguish your work from that of other researchers.

For help with submissions, please contact: **JPMHNedoffice@wiley.com**

We look forward to your submission.

Data Protection

By submitting a manuscript to or reviewing for this publication, your name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services, and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed.

Preprint Policy

The Journal of Psychiatric and Mental Health Nursing will consider for review articles previously available as preprints. Authors may also post the submitted version of a manuscript to a preprint server at any time. Authors are requested to update any pre-publication versions with a link to the final published article.

2. AIMS AND SCOPE

The Journal of Psychiatric and Mental Health Nursing is an international journal which publishes research and scholarly papers that advance the development of policy, practice, research and education in all aspects of mental health nursing. We publish rigorously conducted research, literature reviews, essays and debates, and consumer practitioner narratives; all of which add new knowledge and advance practice globally.

All papers must have clear implications for mental health nursing either solely or part of multidisciplinary practice. Articles which draw on single or multiple research and academic disciplines are welcomed. We give space to practitioner and consumer perspectives and ensure research published in the journal can be understood by a wide audience. We encourage critical debate and exchange of ideas and therefore welcome letters to the editor and essays and debates in mental health.

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

i. Original Research

Word limit: 5,000 words maximum, excluding abstract and references.

Abstract: 200 words maximum; must be structured under the sub-headings: Introduction; Aim/Question; Method; Results; Discussion; Implications for Practice.

Accessible Summary: 250 words maximum; the purpose is to make research findings more accessible to non-academics, including users of mental health services, carers and voluntary organisations. The Accessible Summary should be written in straightforward language, structured under the following sub-headings, with 1-2 bullet points under each: What is known on the subject; What the paper adds to existing knowledge and What are the implications for practice.

Description: The journal welcomes methodologically, ethically and theoretically rigorous original research (primary or secondary) which adds new knowledge to the field and advances the development of policy and practice in psychiatric and mental health nursing.

Relevance Statement: Only papers relevant to mental health nursing practice will be considered for publication in the Journal of Psychiatric and Mental Health Nursing. We require that corresponding authors submit a statement that in 100 maximum, sets out the relevance of the work to mental health nursing practice. If authors do not convince the Editor in Chief of this, the work will not be considered for publication.

Reporting Checklist: Required - see Section 5.

4. PREPARING YOUR SUBMISSION

Cover Letters

Cover letters are not mandatory; however, they may be supplied at the author's discretion.

Parts of the Manuscript

The manuscript should be submitted in separate files: title page; main text file; figures; COI form.

Title Page:

The title page should contain:

A short informative title that contains the major key words. The title should not contain abbreviations (see [Wiley's best practice SEO tips](#)).

A short running title of less than 40 characters

The full names of the authors

The authors' institutional affiliations at which the work was carried out

Corresponding author's contact email address and telephone number

Acknowledgements.

Ethical statements.

The present address of any author, if different from that where the work was carried out, should be supplied in a footnote.

Authorship

For details on eligibility for author listing, please refer to the journal's Authorship policy outlined in the Editorial Policies and Ethical Considerations section.

Acknowledgments

Contributions from individuals who do not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Main Text File

The main text file should be presented in the following order:

Title, abstract and key words;

Main text;

References;

Tables (each table complete with title and footnotes);

Figure legends;

Appendices (if relevant).

Figures and supporting information should be supplied as separate files.

Style Points

- As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors.
- The journal uses British/US spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.
- Footnotes to the text are not allowed and any such material should be incorporated into the text as parenthetical matter.

Abstract

Abstracts and keywords are required for some manuscript types. For details on manuscript types that require abstracts and/or keywords, as well as how to prepare them, please refer to the 'Manuscript Types and Criteria' section.

Keywords

Please provide up to seven keywords. When selecting keywords, Authors should consider how readers will search for their articles. Keywords should be taken from those recommended by the US National Library of Medicine's Medical Subject Headings (MeSH) browser list at <https://www.nlm.nih.gov/mesh/>.

References

For details on references please refer to the 'Manuscript Types and Criteria' section. References should be prepared according to the *Publication Manual of the American Psychological Association* (6th edition). This means in text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper.

Appendix I. Participant Information Sheet



What are student mental health nurses' perceptions of control and restraint?

PARTICIPANT INFORMATION SHEET

You are being invited to take part in research on student mental health nurses' perceptions of control and restraint. Alice Spiby, Trainee Clinical Psychologist at Coventry University, is leading this research. Before you decide to take part, it is important you understand why the research is being conducted and what it will involve. Please take time to read the following information carefully.

What is the purpose of the study?

The purpose of the study is to qualitatively capture the perceptions of student mental health nurses of control and restraint before they have experienced this for the first time in their career. Understanding the perceptions of student MH nurses prior to their lived experience will help to inform appropriate support systems in relation to debrief, supervision and reflective practice both for student and newly qualified nurses.

Why have I been chosen to take part?

You are invited to participate in this study because you are a student mental health nurse and have no prior experience of engaging in control and restraint.

What are the benefits of taking part?

By sharing your experiences with us, you will be helping Alice Spiby and Coventry University to better understand student mental health nurses' perceptions of control and restraint. This may have implications for the way that nurses are supported both practically and emotionally in their work environments and may also have implications for well-being and clinical skills in the future.

Are there any risks associated with taking part?

This study has been reviewed and approved by Coventry University Ethics Committee.

It is acknowledged that you may be asked to discuss sensitive topics which may have personal implications for you. It is important that you understand that the purpose of the interview is for the generation of data to understand perceptions of student mental health nurses. It is not for the purposes of debrief or supervision regarding the event(s) you choose to discuss with the researcher. You may become distressed during the interview. Please be aware that you can withdraw from the study at any point, including during the interview, up until the interview has been transcribed, two weeks after the interview. At this point, all personally identifiable information will be removed from the transcript. You are also be able to request to re-

engage with the interview should you feel this is something you would like to do: this request must be made no later than 1st March 2020.

If you would like additional information regarding what is available in respect to debrief and additional support, please discuss this with the lead researcher, Alice Spiby (spibya@uni.coventry.ac.uk). You will be given a verbal and written debrief with these details.

1. It is important that you consider what you disclose during the research interview. Control and restraint have a legal framework around them; being used as a last resort, and only with those individuals detained under the Mental Health Act (1983).

If there are concerns that a named individual that you have worked, or currently work, with have acted outside of the law or have violated professional conduct, the researcher will need to discuss with the research supervision team regarding how to proceed further. This will likely involve breaking confidentiality and anonymity and may involve further discussions with course staff, placement staff/ senior management and/ or Police. Relevant policies and procedures of Coventry University and any associated organisation (e.g. Trusts or the participant's University if not Coventry University) will be adhered to if confidentiality may be broken.

Do I have to take part?

No – it is entirely up to you. If you do decide to take part, please keep this Information Sheet and complete the Informed Consent Form to show that you understand your rights in relation to the research, and that you are happy to participate. Please note down your participant number (which is on the Consent Form) and provide this to the lead researcher if you seek to withdraw from the study at a later date.

You are free to withdraw your information from the project data set at any time until the interview is transcribed, two weeks after the interview date. Transcriptions of the interview will be destroyed on or before 30th June 2023. You should note that your data quotes may be used in the production of formal research outputs (e.g. journal articles, conference papers, theses and reports) and so you are advised to contact the university at the earliest opportunity should you wish to withdraw from the study.

To withdraw, please contact the lead researcher (contact details are provided below). Please also contact the Research Support Office (hls.rso@coventry.ac.uk, 02477653805) so that your request can be dealt with promptly in the event of the lead researcher's absence. You do not need to give a reason. A decision to withdraw, or not to take part, will not affect you, or your studies, in any way.

What will happen if I decide to take part?

You will be asked several questions regarding your perceptions as a student mental health nurse regarding control and restraint. This will include thinking about your views generally about the use of control and restraint in secure mental health settings, your perceptions of what it might be like to participate in the use of control and restraint, and your perceptions of the impact the process may have on you personally. The interview will take place in a safe environment at a time that is

convenient to you. I would like to audio record your responses (and will require your consent for this), so the location should be in a quiet area. The interview should take up to forty-five minutes.

Data Protection and Confidentiality

Coventry University is the sponsor for this study based in the United Kingdom. The researcher will be using information from you in order to undertake this study. Coventry University will act as the data controller for the study. This means that Coventry University and the researcher are responsible for looking after your information and using it properly.

Your data will be processed in accordance with the General Data Protection Regulation 2016 (GDPR) and the Data Protection Act 2018. All information collected about you will be kept strictly confidential. Unless they are fully anonymised in our records, your data will be referred to by a unique participant number rather than by name. If you consent to being audio recorded, all recordings will be destroyed once they have been transcribed. Your data will only be viewed by the researcher/research team. All electronic data will be stored on a password-protected computer file on an encrypted USB stick. All paper records will be stored in a locked filing cabinet on Coventry University Premises. Your consent information will be kept separately from your responses in order to minimise risk in the event of a data breach.

Your rights to access, change or move your information are limited as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

All collected data will be destroyed on or before 30th June 2023.

Data Protection Rights

Coventry University is a Data Controller for the information you provide. You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation and the Data Protection Act 2018. You also have other rights including rights of correction, erasure, objection, and data portability. For more details, including the right to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk. Questions, comments and requests about your personal data can also be sent to the University Data Protection Officer - enquiry.ipu@coventry.ac.uk

What will happen with the results of this study?

The results of this study may be summarised in published articles, reports and presentations. Quotes or key findings will always be made anonymous in any formal outputs.

Making a Complaint

If you are unhappy with any aspect of this research, please first contact the lead researcher, Alice Spiby (spibya@uni.coventry.ac.uk). If you still have concerns and wish to make a formal complaint, please write to:

Dr Magdalena Marczak
Research Tutor
Coventry University
Coventry CV1 5FB
Email: Magdalena.Marczak@coventry.ac.uk

Dr Lesley Harrison
Clinical Tutor
Coventry University
Coventry CV1 5FB
Email: lesley.harrison@coventry.ac.uk

In your letter please provide information about the research project, specify the name of the researcher and detail the nature of your complaint.

Appendix J. Coventry University Ethical Approval



Certificate of Ethical Approval

Applicant:

Alice Spiby

Project Title:

What are student mental health nurses' perceptions of control and restraint?

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as Medium Risk

Date of approval:

28 November 2019

Project Reference Number:

P97224

Appendix K. Consent form

Participant
No.



INFORMED CONSENT FORM:

What are the perceptions of student mental health nurses concerning the role conflict of engaging in control and restraint?

You are invited to take part in this research study for the purpose of collecting data on student mental health nurses' perceptions of engaging in control and restraint on locked mental health wards.

Before you decide to take part, you must **read the accompanying Participant Information Sheet.**

Please do not hesitate to ask questions if anything is unclear or if you would like more information about any aspect of this research. It is important that you feel able to take the necessary time to decide whether or not you wish to take part.

If you are happy to participate, please confirm your consent by circling YES against each of the below statements and then signing and dating the form as participant.

1	I confirm that I have read and understood the <u>Participant Information Sheet</u> for the above study and have had the opportunity to ask questions	YES	NO
2	I understand my participation is voluntary and that I am free to withdraw my data, without giving a reason, by contacting the lead researcher and the Research Support Office <u>at any time until the point of transcription: two weeks after the date of the interview.</u>	YES	NO
3	I have noted down my participant number (top left of this Consent Form) which may be required by the lead researcher if I wish to withdraw from the study	YES	NO
4	I understand that all the information I provide will be held securely and treated confidentially	YES	NO
5	I understand that I will take one copy of this consent form, and that a further copy will be kept securely by the researcher (and subsequently destroyed in accordance with GDPR, on or before 23 rd June 2023)	YES	NO
6	I am happy for the information I provide to be used (anonymously) in academic papers and other formal research outputs	YES	NO
7	I am aware that if I choose for the interview to be conducted via Skype (as opposed to in person, or via Zoom or Whatsapp), that this is not a guaranteed secure network, therefore the interview could be heard by a 3 rd (unknown) party	YES	NO

8	I am happy for the interview to be <u>audio recorded</u> and subsequently transcribed – at which point all personally identifiable information will be removed from the transcript.	YES	NO
9	I agree to take part in the above study	YES	NO

Thank you for your participation in this study. Your help is very much appreciated.

Participant's Name	Date	Signature
Researcher	Date	Signature

PARTICIPANT DEBRIEF SHEET

Thank you for your participation in the current study: ***What are student mental health nurses' perceptions of control and restraint?***

1. Aims of the current study

The aim of the current research study is to understand student mental health nurses' perceptions of the role conflicts and the use of control and restraint.

2. Rationale and Clinical Implications

The rationale for the current study is threefold. Firstly, previous research has adopted a quantitative approach and it is acknowledged that this area would benefit from exploration from a qualitative approach (Bowers, Alexander, Simpson, Ryan & Carr-Walker, 2007). Secondly, the process of control and restraint has been identified as being traumatic for all involved (Bonner, Lowe, Rawcliffe & Wellman, 2002). In a climate of trauma-informed care, it would be appropriate to fully understand the potential misconceptions and challenges perceived by mental health nursing students in order to promote proactive support and management ahead of the students' involvement in control and restraint as a qualified member of staff. Finally, there is a paucity of research concerning the perceptions of student mental health nurses in relation to control and restraint: this is a potentially vulnerable position which requires additional consideration.

Understanding the student MH nurses' perceptions of control and restraint has implications for the clinical practice of nurses and implications for their nurse training. It is well documented that control and restraint elicits an internal conflict for the staff member who is integrating their identity as carer whilst re-traumatising the service user in a bid to take control and provide effective care (Lach, et al., 2016; Sweeney, Clement, Filson, & Kennedy, 2016). Understanding the perceptions of student MH nurses prior to their lived experience will help to inform appropriate support systems for novice staff members in relation to debrief, supervision and reflective practice.

Given high rates of intention to leave the profession, especially during the initial post-qualification years (Yeh & Yu, 2009), the current research may indicate potential avenues for enhancing the preparedness of novice nurses. This may include, for example, the facilitation of more appropriate control and restraint training.

3. More information

If you would like to have a copy of the final research report, please contact the Lead Researcher Alice Spiby (spibya@uni.coventry.ac.uk).

4. Further Support

It is recognised that you may have discussed some sensitive issues over the course of the interview. If further support is required, please consider the following options:

- a. Talking with your University tutor or placement supervisor**
- b. Using student support services**
- c. Calling the Samaritans:** Call free, any time: 116 123
- d. Accessing Mind:** either call 0300 123 3393 (lines open 9am – 6pm, Monday to Friday) or for more options (including text and webchat) go to:
<https://www.mind.org.uk/information-support/helplines/>
- e. Accessing other local health services:** You can make an appointment with your GP or self-refer to a local IAPT service to discuss further support you may need

Thank you again for your participation

Appendix M. Interview Schedule

Can you tell me how you became interested in becoming a mental health nurse?

- *What type of work do you see yourself doing when you qualify?*

What do you think about working in acute and secure mental health services?

- *What do you think the environment is like?*
- *What do you think of the characteristics of service users who access these services?*
- *What are your thoughts about this?*
- *What are your feelings about this?*
- *What do you expect it might be like?*

What is your understanding of control and restraint?

What are your thoughts about the use of control and restraint with service users?

- *What are the positives and negatives of control and restraint?*

I've asked about what you personally think about control and restraint, now we're going to think about this from the perspective of a professional...

What do you think about engaging in control and restraint as a mental health nurse?

- *What do you anticipate your role would be in a restraint?*
- *What are your thoughts about this?*

Do you have any concerns about being actively involved in control and restraint?

- *Can you tell me more about them?*

How do you think you will respond to being actively involved in control and restraint for the first time?

- *How do you expect to manage how you respond to this experience?*

How do you think this would affect your relationship with the service user?

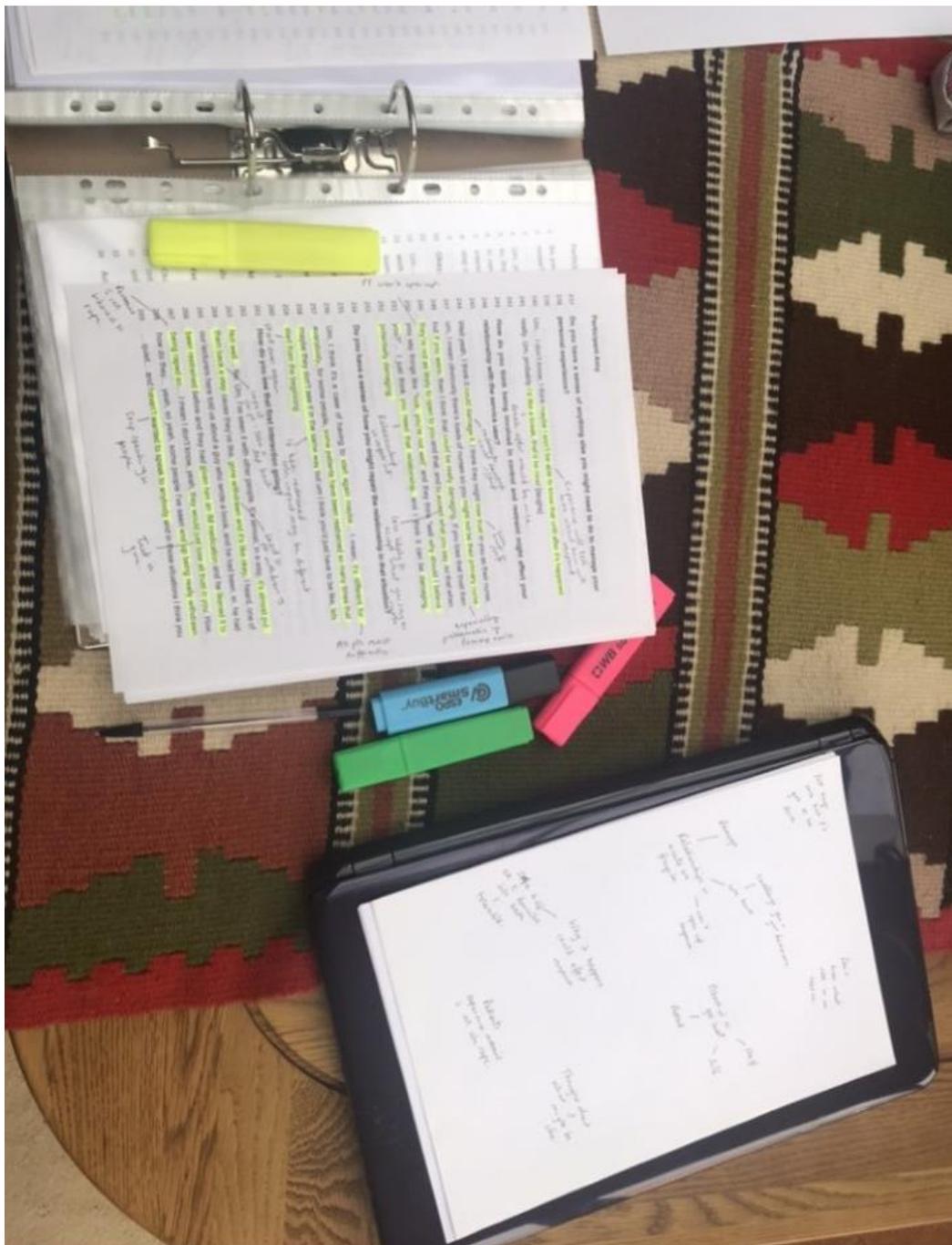
- *How do you think you would engage with them after this experience?*
- *How do you think this would affect your relationship with your colleagues?*

What, if any, support do you think you may need after being involved in control and restraint?

- *How confident are you that this support is available to you?*
- *Would you know how to access this?*

Is there anything else you would like to tell me that I haven't asked about?

Appendix N. Process of analysis



Reading of transcripts with initial coding and thoughts

223 Do you have a sense of what the steps would be to rebuild the ladder?
 224 Uh. Sitting, sitting down with them and telling them, in total transparency really, why
 225 you did that, why it was necessary and how, even saying, I didn't enjoy doing that to
 226 you, I'd rather not do it again, let's work on some things we can do to prevent that...
 227 so yeah it's just transparency and things come back with that.
 228 And like you said, time can be helpful. How do you think your relationship with
 229 your colleagues would be affected by being in control and restraint?
 230 [intake of breath] I know that people have different opinions about when is, when is
 231 the best time to do it, when you shouldn't do it, so I think... rationales can be different
 232 for things I think. Yeah... We all have different opinions on how and when. I think some
 233 people... are more okay with restraint, and some people aren't so there can be
 234 different opinions and I think, you can work through those differences, but again, it
 235 takes time [laughs] but we don't always have that [laughs]. Mmm.

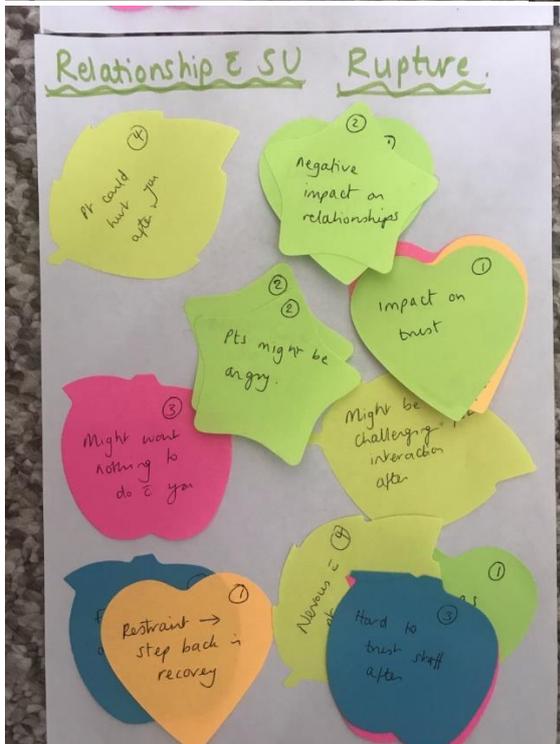
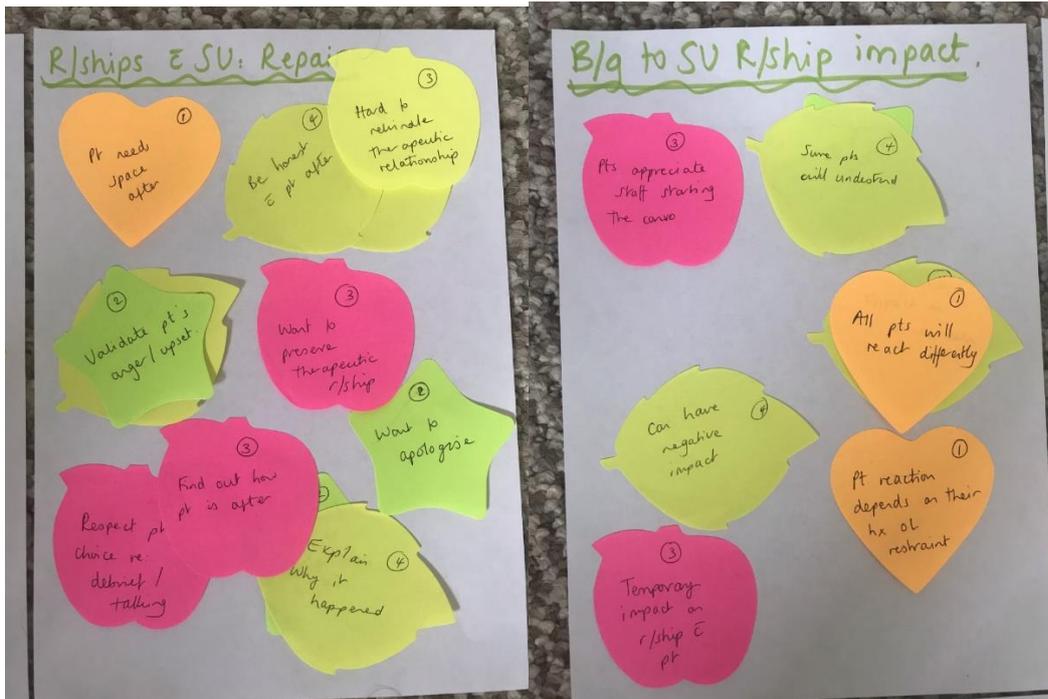
Expectation was necessary. restraint. collaboration. Mr. enjoyable.

openness. Repair. Work to prevent.

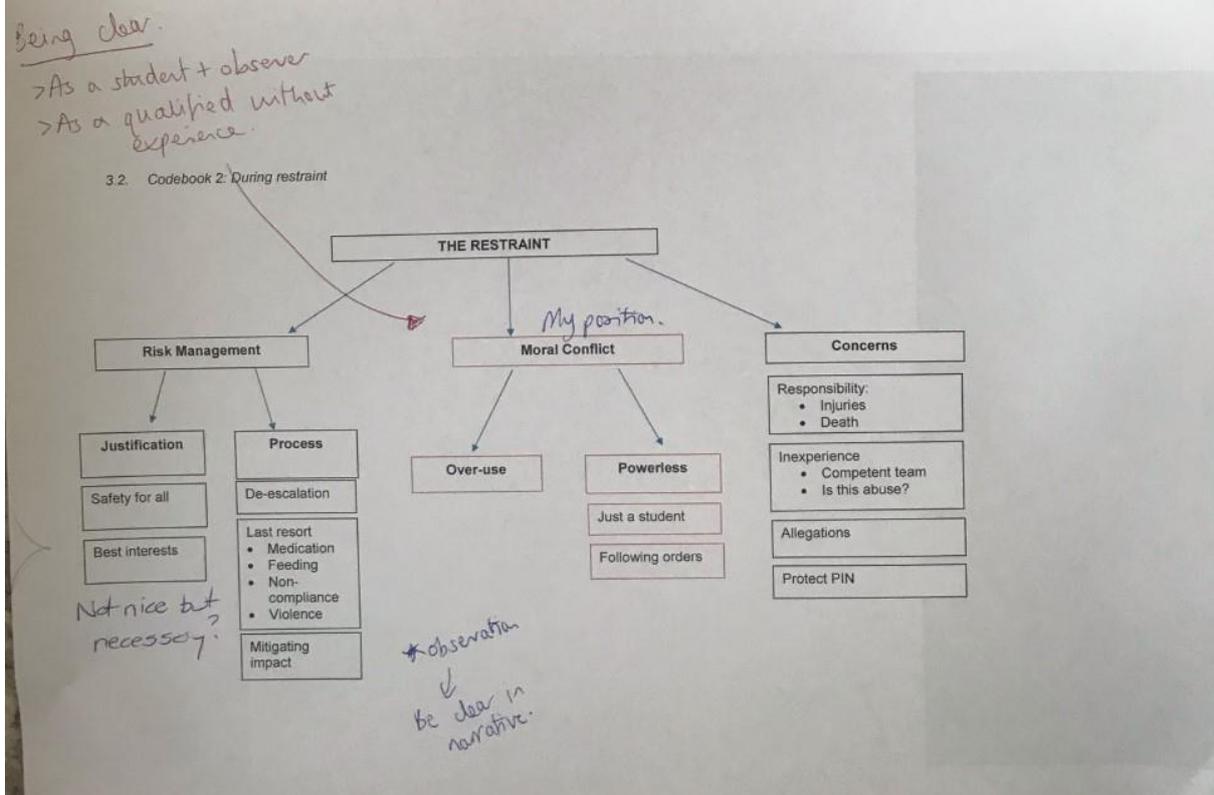
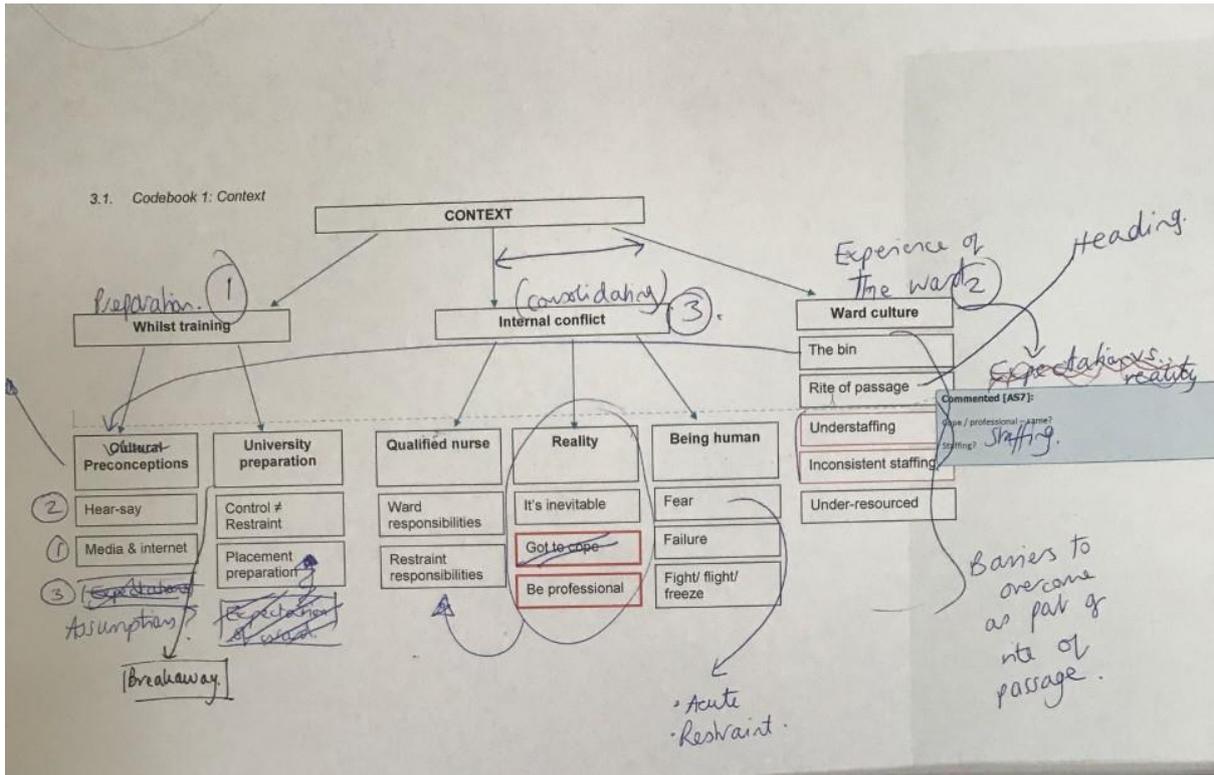
idiosyncratic.

There is good time to restrain. Effortful. Difference of opinion. Work through difference. Can't always do what's needed due to him.

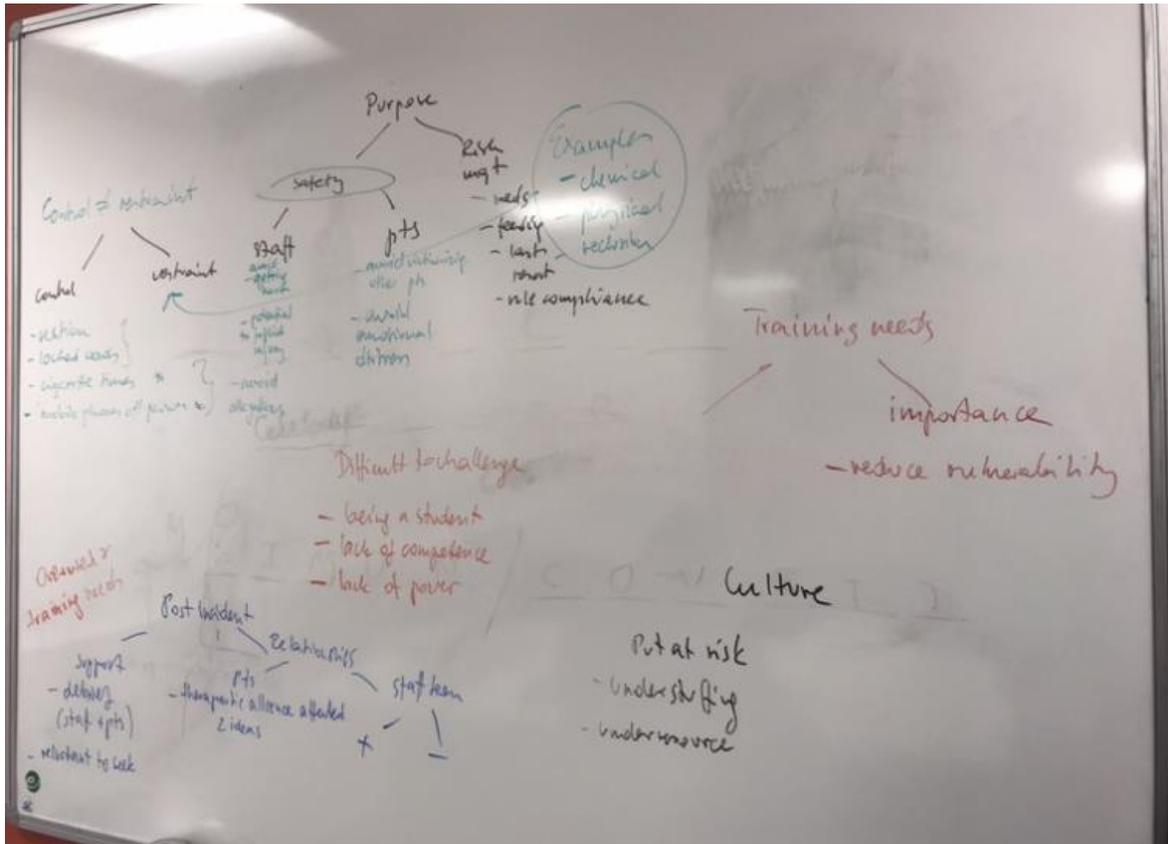
Extract of coded transcript



Evidence of initial codes from transcripts 1-4 building to initial themes



Codebooks modified during supervision - review of quotes to underpin codes and themes to promote consistency



Supervision to identify emerging themes and inter-connectedness of themes for codebooks

Appendix O. Further examples of quotations to support themes

Table 10. Frequency of themes

Pseudonym	Themes									
	During training	Rite of passage	Being human	Justification	Restraint happens	Passive observer	Concerns	Relationships	Post-incident support	Reality check
Amy	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Nick	✓	✓	✓	✓	✓		✓	✓		✓
Sarah	✓	✓	✓	✓	✓	✓		✓	✓	✓
Molly	✓	✓	✓	✓	✓			✓	✓	
Michael	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Simon	✓	✓	✓	✓	✓		✓	✓	✓	
Emily	✓	✓	✓	✓	✓		✓	✓	✓	
Laura	✓	✓	✓	✓	✓		✓	✓	✓	✓
Lucy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rosie	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Heather	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Freddie	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rachel	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Cheryl	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Ella	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

CODEBOOK 1: CONTEXT

During Training

Subtheme: University Preparation

- “We have a little, a little bit of violence and aggression training but it is literally just like okay, here’s some breakaway techniques for getting us away from people which don’t always work” (Amy, 293-5)
- “I definitely worry that I wouldn’t be, like... I don’t know, competent, to sort of, you know, be the lead nurse on the ward if I started working... if I didn’t have the right, I don’t know, preceptorship experiences” (Nick, 58-60)
- “you get taught all these things in Uni like how to talk to people, how to, um, have these like helping relationships with people and I was there like oh god I’ve got so much on my mind, you know, and these people are just walking round and back then it’s like, it’s like, them and us” (Sarah, 107-10)
- “I think the non-voluntary part is probably not great for someone’s mental health in the sense of they’re, they’re stuck in this place that they’re not allowed out of if there’s actually no choice, so stuff like that, again restraint is probably distressing for other service users and just the way sometimes they are run, maybe not allowing phones, like leave, restricting someone’s leave, that can be really, um, restricting for that person” (Molly, 40-5)
- “My understanding is not a lot... but, um, I know that you get trained in it over five days, and it’s more of a trying to control someone if they are acting out kinda thing, I don’t know a lot about it” (Molly, 98-100)
- “The 5-day MAPA [management of actual or perceived aggression] training, that would build up my confidence” (Michael, 220)
- “I suppose that overlaps with risk, and controlling the environment” (Michael, 81)
- “Control would be de-escalation [laughs] and then restraint is the point we don’t want to get to but sometimes unfortunately have to” (Simon, 94-5)
- “We’re the only field that’s taught it [control and restraint] so... I mean, we have stigma about that amongst the year in that we have to have this violence and aggression training” (Emily, 129-131)
- “We can give medication covertly then I guess that would be a form of control” (Emily, 200-1)

- “Restraint in my mind is physical restraint, it is holding people down whether that’s completely to the floor or holding them to a bed, or um, holding onto their arm, um. In terms of control, we can be quite controlling in terms of saying what people can and can’t do, that’s a form of control in itself, rather than letting people have control over that themselves like whether they can even go out. So like, under Section 17 of the Mental Health Act, people are saying ‘*oh I can’t do that, I don’t have Section 17, I don’t have that*’, and that is a phrase I hear quite a lot, and that is something that is probably even more damaging for some people than being held down” (Emily, 139-147)
- “It’s the whole, like, unfortunate reality that people might be strapped to beds, which we got taught about” (Laura, 26-8)
- “There’s the risk of physical harm, which we’ve been trained for” (Laura, 70)
- “Because I’ve banked I’ve done well what they call in my trust PMVA so I’ve done the 5 day training and it was really... good for me in some ways” (Lucy, 99-100)
- “We’ve just done a lecture on it in like a couple of weeks ago, so I’m still trying to get my head around it” (Rosie, 109-10)
- “Even like protected mealtimes is kinda like a control isn’t it?” (Rosie, 120-1)
- “We used to get a lot of preparation for going into a general hospital but then being in second year, I just feel like we don’t get taught, we don’t really talk about what to expect” (Heather, 173-5)
- “Cause I don’t really know what to expect like I don’t know how to prepare, I don’t know how to feel prepared for it” (Heather, 290-1)
- “As students we do breakaway, breakaway training whereby we don’t get involved in to real phys-physical restraint but if we are in work, not as a student, you would get involved in it” (Freddie, 109-111)
- “I feel like if anything the control part can be worse than restraint” (Rachel, 249-50)
- “I haven’t seen it very much so I’m not quite sure and obviously I’m not trained it in” (Rachel, 257-8)
- “My idea of control is the kinda idea that people can’t get out of these locked wards, they can’t just leave when they want to, we can essentially tell them where to go and what to do, you’re not allowed in that room, no you can’t have a razor today, and things like that” (Rachel, 141-4)

- “This is the thing, right, um, here in [University] they don’t say much about it. So what... the most I’ve learnt about it has been through placement and I haven’t even like seen it being done on placement” (Cheryl, 84-6)
- “I don’t really have much knowledge, all I know is that there’s a certain way they do it that’s like safe, and then, it can happen for... some duration of time” (Cheryl, 87-9)
- “I don’t know how to approach challenging behaviour so if someone started walking toward me, although I know I need to, I know how to, like, remove myself from certain grips, um, if somebody attacked me, I wouldn’t know how to respond, it’s not something we’ve been taught, and I feel like we should be taught that and in terms of, um, like, restraint, I don’t know proper technique and things like that and if I observed it, so I feel like we should have more training on like, um, confrontational behaviours” (Ella, 75-80)
- “I would feel a lot more confident if, er, there was more of a hostile situation, um, if somebody was, like, confrontational, um, I feel like I’d be able to better manage it if I knew what I was doing and had more confidence in it” (Ella, 84-86)
- “I just enrolled in the bank so that I can get on the PMVA [prevention and management of violence and aggression] training” (Ella, 326)
- “Hopefully from doing the training I’ll know the right way to do it, um, and I’ll know all the paperwork so’s other people can be informed as to like what happened in the scenario, things like that, and I guess it means that if I do witness it as a student then I know that what I’m watching is the right way to do it” (Ella, 351-4)

Subtheme: Preconceptions

- “I’d seen documentaries and stuff and it was better than that because I think what you see on TV it’s always like the worst-case scenario” (Amy, 91)
- “I had an image before I started of this being somewhere, you know, completely locked down and people can’t go anywhere without, you know, just can’t go anywhere, can’t leave” (Nick, 37-39)
- “it’s just a story from another person, but somebody who I can’t imagine has been trained to be involved but someone who is probably quite a big, er, been there a long time and has... big personality, and apparently got involved in restraint...

anyway I don't know if that's true, again it's just a story I heard from somebody" (Nick, 160-3)

- "I was like, is it all, am I going to walk in and people are gunna be shouting and tryna fight people or like screaming or stuff" (Sarah, 118-9)
- "I've heard stories of nurses [laughs] injecting the wrong person" (Sarah, 361)
- "I've heard a lot of things good and bad about them and the way they're ran" (Molly, 24-5)
- "I know that it's probably not as chaotic as one might think, if, umm, probably depending on what ward you go to, obviously, but, you know, I imagine it being all guns blazing, fire and stuff, but you know, it probably isn't as bad as you'd perceive it from an outside perspective" (Molly, 91-4)
- [concerning doing an IMI] "I've done my own research but not any teaching, no" (Michael, 193)
- "So, unfortunately, I had that sorta scary old-fashioned asylum kinda thing in my head. I don't know why cause I've kinda seen movies and stuff" (Simon, 78-9)
- "The sorta '*one flew over the cuckoo's nest*' picture that you have is definitely what I thought it would be" (Emily, 123-4)
- "Very much like a hospital but with extra measures put in place like people can't leave the wards, more locked doors and obviously things like you do have to strap people to beds and stuff like that which you wouldn't get in a normal acute setting outside of mental health" (Laura, 43-6)
- "I've heard, heard things but it kinda depends cause from an adult mental health perspective they seem pretty sorta brutal" (Laura, 20-1)
- "Women are obviously a little bit more, a little more pack mentality, aren't they? I'm on about women generally, so like I'm thinking about experiences from school and things" (Rosie, 66-8)
- "I think I'd be scared that if I worked in a hospital I'd develop this weird, almost, like almost like a prison officer persona but I think that's just because of what I've seen in like the media" (Heather, 59-61)
- "I kinda expected before I went in that it would be really scary and it would be like what you see on films and, and on TV programmes where it's really dramatized" (Heather, 93-4)

- “I listened to this Podcast and it was called “On the ward” and, and they kinda showed a more balanced view of it and what it’s like to be on a ward” (Heather, 162-4)
- “I looked up the ward online and things like that and I found a couple of, it was erm a patient mental health forum where people discussed their experiences on different wards” (Rachel, 124-6).
- “I’ve heard in like some older adult settings they use it like just if, if someone’s just starting to like sort of shout or like start like fla-flailing their arms around and things and it’s like, well, if you just talk to them they might calm down... especially with older adults and people with dementia and things, it’s quite easy to talk someone down when they’re in that sort of state” (Cheryl, 121-5)
- “I expect it’s quite terrifying, especially if you’ve not experienced that sort of behaviours behaviour and um, I guess there’s quite a lot of shouting and things, it can be intimidating” (Ella, 90-2)
- “I’ve watched, um, videos about like, um, the benefits and the negatives of restraint and other ways to like divert the behaviour, um, and then I’ve seen videos and like... like possible ways to restrain people, um but obviously YouTube videos aren’t the most reliable sources” (Ella, 333-6)

Rite of passage

- “I think people think of it as a way of getting more experience when you’re newly qualified, almost treating it like, um, a last placement” (Amy, 23-5)
- “There’s an idea about earning your stripes” (Amy, 35)
- “It’s a great experience but like it isn’t the best experience for the patient” (Amy, 66-7)
- “There’s a lot of pressure and responsibility on the nurses there, so... you could be working on your own especially on night shifts and stuff” (Nick, 54-5)
- “I’ll get my skills up as a newly qualified nurse you’d be able to see a lot of different presentations so it’s good for your kinda medication skills, um, management as well like being able to coordinate shifts so I think it would be quite good” (Sarah, 21-4)

- “you just don’t know what could come near you every day, completely different every day you go there, different service users, different environment, all the time” (Molly, 76-8)
- “It ranged from like 18-year-old boy right to a 60-year-old man and it was like personality disorders, psychosis and, erm, depression and all sorts” (Michael, 40-2)
- “It feels like it would be a good foundation to start off with” (Michael, 21-2)
- “If it was properly staffed and there was more staff to service user ratio... there would be a lot more of sorta verbal de-escalation rather than physical restraint” (Simon, 114-6)
- “More facilities and we could manage that better. If there were more wards [laughs] so we could, yeah, get to give those people a bit more support” (Simon, 46-8)
- “I think with the right staffing and the right approach to inpatient and the realisation that it is only temporary that it can be a good thing, but I don’t think that’s always the case, I think people can become quite institutionalised especially if they’ve had mental health difficulties from quite young, then they stay in these units and stay on secure services and then they get a reputation” (Emily, 39-44)
- “Straight after being registered I want to be constantly surrounded by it, all the time. Probably because I’m young and naïve and I think that’s where I’m going to learn best and I have the energy now to do it and the passion still in my head to be round people all the time and to be really in it” (Emily, 27-31)
- “It’s not even an if, it’s when, I know that I’ll have to do it at some point in my career just because of the... yeah... I just, it definitely will happen, and I’m okay with it, I just wish I didn’t” (Emily, 178-80)
- “Chance that people are more likely to be violent in an acute setting... obviously because they’re being kept against their will” (Laura, 28-9)
- “People who can’t really cope out, out in the community essentially. They’ve gotten to the point where they’re in such a state with their mental health that the safest place for them to be is in a hospital” (Laura, 51-3)
- “I think short staffing makes a massive difference, you know if we had enough staff to be able to offer therapeutic approaches to people you know we, we have

staff, we're plugging holes with, with you know, agency staff, which needs doing but actually they don't know the ward, they don't know, you know, each other, so that team, erm, feeling kind of isn't there" (Lucy, 88-92)

- "Acute wards, were noisy... lack of privacy, um... they're much more like a sticking plaster on someone's mental health rather than a recovery... process" (Lucy, 35-7)
- "You have to serve your time on the acute wards to be a good nurse and to understand it, which, etc I don't personally agree with" (Lucy, 51-2)
- "I think it would be good for like, my personal development cause I am a really caring person but I can probably be a bit... soft" (Rosie, 73-4)
- "It's almost like you're not a real nurse if you haven't done, spent some time in a hospital after you've qualified" (Heather, 44-6)
- "They're kinda, just being, almost being held there, like sometimes they're just there for the sake of it because they haven't got somewhere else to go" (Heather, 54-5)
- "All kinds of things that are happening in acute" (Freddie, 44)
- "I feel like that's a place I need to be in terms of learning and upping my skills and learning more about, for example, medication, interventions, and therapies" (Freddie, 31-33)
- "The amount of things and different people that I saw, different diagnoses and different experiences, even with kinda physical health, people coming in and out of the door not with just, say, depression or schizophrenia, but with different physical health conditions" (Rachel, 23-31)
- "It was just such a rapid learning experience that I feel like spending even just a year on there you could gain so much that you could then take to different areas" (Rachel, 31-3)
- "I think it's quite... daunting to think that that's gunna, I mean especially on an acute ward it's almost inevitable" (Rachel, 224-5)
- "Basically every other day we have someone come in who is like... a bit difficult to manage, like kinda hard to get like, hard to get to know them cause they're a bit... not very well, yeah, and erm, sometimes they're, sometimes they'll have like a, sort of like, like an edge to them" (Cheryl, 27-30)

- “I feel like it’s a lot of revolving door patients, erm, and there’s quite a lot of drug-induced psychosis which I think makes it quite difficult to treat” (Ella, 36-7)
- “I feel like it’s somewhere where you benefit quite a lot, like, educationally” (Ella, 69-70)
- “With short-staffing, with like, wards... seeing increased behaviours so like, um, I’ve, I’ve noticed that people want you to take on more patients but they want less staff on the wards so it makes it quite difficult to deal with everybody at the same time” (188-191)

Being Human

- “I’d just have to get on with it” (Amy, 230)
- “I am quite nervous about it” (Amy, 399)
- “I guess that’s something that I don’t feel I am qualified or competent to do, cause I have no experience of it so the idea of it’s pretty daunting” (Nick, L117-8)
- “I’d probably be very anxious and... scared and... worried that I’m doing it right and worrying that it’s warranted” (Nick, 140-141)
- “I was quite scared because, again, I’ve never been... I was straight from sixth form really so... it was... I didn’t... yeah, it was weird” (Sarah, 106-7)
- “it was just fear of the unknown I guess, didn’t know what to expect so I was walking in blind” (Sarah 120-1)
- “I don’t want to do it, but... it’s... I’d have to, really, if that’s the job I’ve signed up for but I’d always wanna make sure that I do everything in my power to not do it because... I... obviously it doesn’t appeal to me, I don’t want to be doing that to someone” (Sarah 180-2)
- “Yeah, it’s scary, very scary because it’s like, you know, there’s this vulnerable person, this service user that you don’t wanna upset or distress more and you also wanna keep your staff safe so there’s a lot of responsibility on your hands with both service user and the, and the staff but you know, it’s the responsibility you take on as a staff nurse so it’s kinda weighing up, this is my job, you just need to take the higher ground in that sense” (Molly, 181-6)
- “Sometimes you’re, not out of your depth but cause it’s your first experience it can be quite daunting” (Michael, 52-3)
- “It’s something I dread” (Michael, 147)

- “I think it would be quite scary for me, yeah, and it will be a bit... I wouldn’t feel right afterwards, I think I’d feel a bit, I dunno, shaken up, as they will probably [also feel shaken up]” (Simon, 189-190)
- “We’re there to look after them, and sorta restraining someone doesn’t sit with my morals properly” (Simon, 113-4)
- “I hope that I’d be quite professional about it as well but, um, I’d probably remove myself from it and just physically act and I would try not to think about it too much” (Emily, 271-3)
- “Making sure I follow the training, following the guidelines I’ve been given and, um, understanding, understanding why I’m doing it and being clear in my head” (Emily, 280-2)
- “I would be nervous. I would be quite tense” (Emily, 86)
- “I don’t like how aggressive it is, or how restrictive it is to people but, but it comes with the territory” (Emily, 158-9)
- “I would be quite apprehensive [about being in an acute or secure environment] at first” (Laura, 63)
- “I would be nervous initially going in and throughout the day depending on what happens, I’d either calm down or [laughs] I’d get more anxious” (Laura, 76-8)
- “Be aware that you’re not, in my case, superwoman, and that on occasion you do need other people to come and help but to try and do that professionally, calmly, erm, with clear and calm instructions” (Lucy, 196-8)
- “If we restrain, we have to do so non-emotionally and that’s really difficult to do” (Lucy, 198-9)
- “It’s a little bit nerve-wracking” (Rosie, 183)
- “I don’t feel comfortable with all that so that, I’ve got that kind of fear about that situation as well” (Heather, 143-4)
- “I suppose when I qualify I’ll probably know more about it, and I might know what to expect by then but at the minute, as I see it now, I’d be, I’d be really like nervous about it” (Heather, 272-4)
- “You feel very unprepared going in so very nervous” (Rachel, 102-3)
- “Remaining this kind of physical and therapeutic person in that situation” (Rachel, 294)

- “Okay this is necessary let's go we're going to do what... we can do this as long as we do it properly it's fine... but it will be more kind of just blocking out like all the feelings around it” (Rachel, 329-31)
- “I won't be happy, but it will be in my job description in areas like that” (Freddie, 175)
- “I think it would probably upset me quite a lot... yeah... cause... in an ideal world, I don't really wanna restrain someone” (Cheryl, 213-4)
- “I feel quite nervous... um... there's a lot of behaviour that I don't know how to deal with just yet as a student” (Ella, 68-9)
- “It's something that worries me a lot. It's not something I particularly want to engage in” (Ella, 209-10)
- “I'm quite good under pressure in the moment so I think I would... sorta, you just get on and do it and I think I'd be okay then but then I think when you have a quiet five minutes it'd really upset me and I think it'd really quite affect me and I'd quite struggle with the fact that you've taken somebody's freedom away from them and it's quite a... like an intense thing to do” (Ella, 234-8)

CODEBOOK 2: MORAL DILEMMA

Justification

- “They might try and hurt other patients or hurt members of staff and then it's, obviously important then” (Amy, 174-5)
- “As a nurse you want to help people and I know that it's in their best interests” (Amy, 162-3)
- “If someone is refusing their medication and it is care planned and they have, they are on a section, and they need that medication to help them improve, then they need that medication, and that means IM-ing them during a restraint” (Amy, 175-8)
- “I don't like the idea of doing it at all, I would never want to do that to somebody if it was avoidable, but as I said, I imagine there are times when it's unavoidable and it's probably in the person's best interests” (Nick, 109-11)
- “I do understand why it happens in, to protect themselves and to protect the other uh patients there so I understand it” (Sarah, 131-2)

- “So it’s usually if people won’t take their medication or, so that is if [clicks tongue] so say it’s a medication that they’re refusing to take their antipsychotic or something and... they keep refusing they will be told and told for several times, or if someone is being very aggressive where there’s a risk of themselves or other people, other patients, or staff getting hurt” (Sarah, 139-43)
- “I do think it’s good if someone is really not reacting to just talking methods then it’s probably good for that, for containing them in that moment if there’s a danger to themselves or them, or others especially” (Molly, 121-3)
- “From what I’d like to think, that only very acutely... dangerous situations it would be used” (Molly, 127-8)
- “It’s not nice to think that you’d be distressing someone more by using that force on them, however I do think that, er, if it’s needed in that moment it’s kinda weighing up the pros and cons of what if it’s needed or not, I think that’s the most important... you don’t wanna get hung up on restraining people all the time, where if there’s another reason not to I think that’s better, yeah.” (Molly, 162-7)
- “If it’s diminishing the risk” (Michael, 172)
- “When someone is a risk to themselves or others that needs to be managed to keep everyone safe and in a safe way” (Simon, 92-3)
- “I understand the need but it’s sort of, rubs my hairs the wrong way. I can understand that it needs to happen, it needs to be done for people’s safety, but it doesn’t fit right with my own ethics” (Simon, 107-9)
- “As long as I’m helping somebody, if that is part of the intervention, like, if I can understand why it’s going to help them to get to their best recovery state then I will oblige” (Emily, 392-4)
- “I’ve seen restraint used even in an older patients ward because they’re so unstable they could do harm to themselves and that, if that isn’t done, well that’s the horrible truth” (Emily, 133-5)
- “Obviously there’s positives because you’re doing it to make sure the patient is safe and gets better” (Laura, 147-8)
- “We’d be doing it in the best interests of the patient, so like if it was the example of feeding, obviously if that person doesn’t get food, then they get very ill and then they probably get worse in their mental health as it deteriorates more so it’s kinda like the greater good” (Laura, 144-7)

- “It is the last resort and it is the only thing that will keep me, other staff, that patient safe” (Lucy, 182-3)
- “It’s not a pleasant experience and you know... I’d like to not do it but I’m aware on some occasions for safety we have to bu-but it should be, it shouldn’t be the norm.” (Lucy, 228-30)
- “They had to restrain teenage girls so they can be tube fed, and it goes against every instinct you have, I think, well, certainly mine, however, if you don’t do it, these girls will die.” (Lucy, 112-4)
- “As it’s like best interest and you know, cause all the other de-escalation techniques haven’t worked” (Rosie, 138-9)
- “When somebody is really quite ill you know and, you know you, they’ve maybe not taken their medication for a few days, so they’ve got that point where they need their medication and maybe they’re getting quite violent, like hitting out at staff or throwing things, so you might unfortunately have to restrain them to give them medication” (Rosie, 111-5)
- “You know, providing that, you know, what you’re doing [sigh] it’s not going to be good for them, at that moment in time maybe, but providing it gets them to a place where they can maybe get the support they need afterwards” (Rosie, 242-4)
- “To make that person safe and if they were doing something to harm themselves or even other people it would just be to keep them safe” (Heather, 218-20)
- “Some of these patients attack others and if you don’t intervene physically, someone is going to get injured” (Freddie, 152-3)
- “In certain experiences that I’ve seen there wasn’t really any other way to safely bring a situation down to protect the other service users around that person, to protect staff and to essentially protect the person as well” (Rachel, 151-4)
- “I think, er, if the person is becoming a risk to themselves it’s best to make sure that they’re just, safe, you know, you don’t want to have someone who’s banging their head on a wall, you might have to just go, right, time to restrain them or I have like on my placement it was like two weeks ago there was a patient who came at one of the nurses with a knife... so, then they had to restrain the patient obviously, so, in that case I’m like, well yeah, what else could you do? What, just let the person stab the nurse? No” (Cheryl, 101-107)

- “I’m also aware that if somebody is very hostile or... erm, very aggressive, um, if it’s what’s necessary then I’d be happy to do it because I know it’s what’s best for the patient and everybody in that environment” (Ella, 210-2)

Restraint happens

- “It would be helpful to know what’s expected of me, if more nurses were like saying about their experiences when they first did it, but they don’t really” (Amy, 296-8)
- “They’re usually planned, so, if um, yeah, say somebody was refusing their medication and they knew they were going to have to IM them, then they’d have to be very careful cause you can’t be like ‘if you don’t do this then they’ll do that’ you can’t say that so it wasn’t, um, put as like a threat” (Amy, 108-111)
- “if I was a nurse, and I was the most qualified person there, it might be my decision to initiate the restraint so, um, if there were lots of other more experienced people there my role might be to just be part of it... just take part in the restraint” (Nick, 103-5)
- “The only thing I can say is that there’s probably some times when it’s necessary but you’d always hope that every other possibility was exhausted before going to the point of restraint.” (Nick, 96-99)
- “I think it should always be a last resort and I have seen it really be a last resort” (Sarah, 126)
- “Talking people down is obviously a massive thing, like you should never jump straight to medication, always try and find out why they’re distressed before you know sticking medication in someone, or, uh, restraining them” (Sarah, 161-4)
- “The nurses will sorta... take the lead I guess. Um, every I mean healthcare assistants, everyone, they’ll be trained to, PMVA trained to restrain as well, but I guess you’ve gotta take the leadership role” (Sarah 191-3)
- “You should try to understand the service user in the way of what makes them tick, or their differences so if you can see they’re a bit more distressed than usual, talking to them about it before it escalates” (Molly, 139-141)
- “Yeah, they do IV as well, so obviously like restraining someone and they inject them with medication like, um, knock them out for a few hours maybe. That’s another form of it, where they, so they, just knocked out because they’re so

dangerous to themselves or others then they just leave them be for a bit... that's about as much as I know in UK restraining anyway" (Molly, 152-6)

- "I'd think that my role would be kind of trying to get the team to restrain in the most safest possible especially if you're staff nurse running it I think what you do is kind of stand back most of the time and try to like, guide people on what to do" (Molly, 172-4)
- "Maybe if it needed an injection, I'd take the injection" (Michael, 176)
- "We had a meeting after with all the patients, like a weekly meeting, and it came up, like when you do a restraint, restraint, um, try and, can we try and do it in their room so like when no one else is looking cause like when ev-everyone else is looking, it creates such an atmosphere" (Michael, 232-5)
- "There's lots of ways to restrain someone from like, erm, physical restraint to like medication, I think that can go under it" (Michael, 71-2)
- "Restraint can be, uh, physical restraint so restraining someone physically with their arms... it could be environmental so seclusion, taken to their bedroom or de-escalation room, or it could be chemical restraint like rapid tranquilisation" (Simon, 100-2)
- "I'm hoping that the people around me would be properly trained in verbal de-escalation and environmental stuff and I think as a nurse it's important to make sure that my team have those skills" (Simon, 135-8)
- "We should be, as a mental health nurse, be talking, it's what you do, you should be talking to them not holding them down or putting rapid tranq in them" (Simon, 184-5)
- "Unfortunately, it's the coordination of the restraint, and then, if needed, decisions on whether someone needs to be secluded or medication needs to be used" (Simon, 142-3)
- "In my mind it was always a last resort, um, and it's stated as being that but it's not always the way and that's the case with all these kinds of things I found, they say 'oh we never really do this'" (Emily, 152-4)
- "I definitely think that as a nurse I would be expected to restrain, so like, hold them to a bed, to a floor even, or just hold them so they can't get off the ward in some way. I think I could be physically holding them, or I could be orchestrating it" (Emily, 189-91)

- “Administration of medication is something that we would do.” (Emily, 199)
- “I’m not really sure yet to be honest... we’ve been taught like what to do, how to restraint somebody if they like physically attack us but I haven’t been taught yet as to what my actual role is, like, say if it was the feeding example, I don’t know if I would be the person holding the patient down” (Laura, 163-6)
- “I wouldn’t really want to do it unless it was absolutely necessary, like I’d much rather try to coerce, or like, get the patient, coerce them into doing what we wanted them to do rather than forcing them to do this” (Laura, 134-6)
- “I had an experience with a really good nurse who, who, you know this person was written up for oral, you know, medication and IV and, you know, she actually managed to convince him to take the oral medication even though he was under restraint” (Lucy, 217-20)
- “Part of me will feel I’ve failed as a nurse if I can’t de-escalate someone” (Lucy, 249-50)
- “I think you have to know your patient to be able to... to... to really effectively use de-escalation, erm, but non-threatening, it’s got to be non-threatening, it’s got to be person-centred and it’s got to be meaningful, you know trotting out learnt phrases is, you know, not gunna de-escalate, it’s going to piss people off” (Lucy, 167-71)
- “Nurses have led most of the restraints, they’ve also made sure that the person’s physical health has been observed in saying that, HCAs do do that. I guess if it comes to the point where you have to deliver medication, again, that’s the role of the nurse to do that” (Lucy, 207-10)
- “People can use it as a first or second resort rather than a last resort, not sure we, people always remember that, you know, the least resistive process” (Lucy, 143-4)
- “As a nurse maybe I might have to give an injection, you know, I might be in the situation where I would have to give the, the depot injection” (Rosie, 176-8)
- “As long as it’s done, like I say, as the least restrictive and obviously, you wouldn’t want to do any prone, you know, any unsafe restraint would you?” (Rosie, 203-4)

- “I always think that it’s better to try and prevent something, so sometimes it’s about giving someone some space rather than, hopefully not escalating to the point where it could go out of control and it would need restraint” (Rosie, 101-4)
- “Physical restraint that’s holding somebody down but that has to be in the most, safest way as well so you’re not hurting them or putting yourself at risk as well” (Heather, 189-91)
- “I think there’s like a few different types so like there’s chemical restraint which is to do with like, like rapid tranquilisation and that kind of thing or like physical restraint, erm, and it should only be a last resort” (Heather, 182-4)
- “You should try to de-escalate the situation or actually even before that, prevent any kind of distress from happening in the first place, but then trying to do some de-escalation so some talking or maybe some breathing exercises, or, erm, you know any tools that you’ve got in your box” (Heather, 184-8)
- “I don’t know if I’d be there to... to like talk to the person while they’re being restrained or, or if I’d be physically have to be active in that and just, I, I don’t even know the logistics of it” (Heather, 238-40)
- “I think if, if I knew what my role was and I knew what I was supposed to be doing I’d probably feel a bit better about it” (Heather, 246-8)
- “The way it’s done obviously they try, or we try, to do, to put dignity at the forefront of what we do so we don’t embarrass them in front of everyone” (Freddie, 166-8)
- “I can always delegate and ask other people to restrain” (Freddie, 253-4)
- “Personally, I didn’t like it cause that approach of restraining is, er, it’s a last resort thing, but that’s not a last resort at that time” (Freddie, 297-8)
- “If there is a need for medication, need for rapid tranq then the nurse does the medication or relaxes the, the nurse does the medication and communicates to the patient when the situation is calm” (Freddie, 189-91)
- “And then we have the high level one, erm, the high level one whereby you will go on the floor and hold that person. We are not allowed to hold them upside down, like face down anymore so that is stopped, that is, if it happens, it happens as soon as you get yourself together, one of you, whoever is in charge of the restraint, has to instruct and you have to turn up immediately, and you have to bring the person to face up” (Freddie, 220-5)

- “There is something diplomatic you can, you can use before you intervene – you speak to them, or we have distraction techniques, you... apply distraction techniques, erm, divert the person’s mind, make a joke” (Freddie, 272-4)
- “It gets to the point where people have to physically hold somebody, erm, in the safest way possible to administer that care” (Rachel, 137-8)
- “They were like we do need to restrain her and we were honest with her we were like look if you don’t let us give you this medication this is gunna happen and this is how it will work and she said, erm, she, so that was necessary because they’d tried everything else up until that point” (Rachel, 164-7)
- “There’s somebody at the head and somebody kind of leading to make sure you know everything’s done safely, people are on arms and legs depending on how many people are needed” (Rachel, 258-60)
- “With the kind of restraining to give an IM it tends to be people end up kind of lying down and still the holding and things like that but then you know that having to take off things like trousers and that and give that person injections” (Rachel, 263-6)
- “I think sometimes, those, you know, the other two, the other steps to trying to intervene in different ways are missed first” (Rachel, 160-1)
- “if someone’s like just come becoming... like... a bit like agitated, it wouldn’t, it wouldn’t help to restrain them, it would help if you would verbally de-escalate them, more likely so” (Cheryl, 119-121)
- “I don’t know how to restrain somebody, I’ve never... understood what, what you do and what’s correct and what’s not.” (Ella, 100-2)
- “It should only be used, um, as a last resort sort of thing if somebody’s at risk” (Ella, 99-100)
- “I don’t know, um... particularly what nurses do in terms of restraint or the paperwork” (Ella, 216-7)

Passive observer

- “So if someone did [get a high off restraint], or I did come across a person who did enjoy that part of the experience then, I think I would mistrust them a lot” (Amy, 284-5)

- “I’m a student nurse so I was encouraged not to go anywhere near them so you don’t, don’t really see” (Amy, 114-5)
- “Not that you wanna get involved but like I can’t, I can’t do anything and you’re left to, um, calm other patients down which is really difficult because you’re not qualified, you’re not really able to do that” (Amy, 118-120)
- “As a student I couldn’t, you know, I can’t really be, I did see it um, and I think they did have to use rapid tranquilisation on her which is actually really hard if you’re in, like it has to be quite serious to do that if you’re in 136 because they don’t have, um, like the meds written up cause you’re only there like 24 hours so I think they did do that, and then she was in the seclusion room and she was screaming and stuff and like quite horrible but they were like she was here literally last week, same sorta thing happened, so it’s... yeah... but they said that happens a lot there, they see it a lot... “ (Sarah, 325-32)
- “From my experience on the PICU ward it was used quite a bit” (Michael, 104)
- “They know the triggers and the like warning signs, erm, in terms of... in my judgement in terms of whether it was justifiable or not I’m not actually sure to be honest” (Michael, 134-6)
- “Maybe it’s the norm, like I’m the student and, do nurses actually act like that?” (Michael, 159-160)
- “There was one person on my course who actually really enjoyed it, she, she wasn’t a qualified nurse, she was training, and she worried me cause she liked that experience of being hands on” (Lucy, 107-10)
- “People go in, and that might be because last week something went wrong and they were physically assaulted and so they’re scared, and and they don’t want it to happen again so they go in” (Lucy, 145-7)
- “Students aren’t allowed to really respond anyway to the alarms, so... you know, maybe you wouldn’t, you wouldn’t see it as much as when you’re qualified” (Rosie, 187-9)
- “At this stage I wouldn’t know what to do if someone was really distressed, I wouldn’t, I’d be worried that I wouldn’t know how to calm, like help them to calm down, help them to relax, help them to feel more... you know, comfortable, and, and also that fear that I might say the wrong thing and it might make them, well

they might be alright and then I say the wrong thing and then might make somebody upset” (Heather, 135-40)

- “Every day I could see people getting restrained, all the time, somebody was getting restrained around three times, four times a day for challenging behaviour, getting secluded” (Freddie, 64-6)
- “I’ve seen people restraining because they want to restrain, because they are known for restraining, they are qualified nurses” (Freddie, 265-7)
- “This young girl knew that we were not MAPA trained and that we were not allowed to hold her, so she was challenging us all the time, coming to us trying to attack us, every time we told her to stop something or not do something she would go for us because she knew we wouldn’t, we wouldn’t do anything” (Freddie, 127-131)
- [re: challenging decision of a qualified nurse] “There’s not point cause obviously they didn’t listen to me, they’ve got the pin, they say they’ve got the pin, so they’re in charge” (Freddie, 291-3)
- “It’s hard if you’re working in that environment to take off your HCA or support worker hat and put on a student hat” (Freddie, 116-7)
- [re: challenging perceived over-use] “It can be quite difficult because it’s the kinda idea of we-you’re a student, you don’t understand sorta thing, you don’t understand” (Rachel, 193-4)
- “It tends to just get shunted away sorta thing as you’re not restraint trained or anything like that so you can’t, you don’t really have a say in this” (Rachel, 195-6)
- “It can be quite disheartening cause you can kinda be like well what’s the point of me even being here on placement if you’re not gunna take into account anything that I say” (Rachel, 212-4)
- “One of my lecturers mentioned that she had to, er, complain about a member of staff saying “Okay we’re gunna grab um, jab um” sort of thing so I think that kind of, that kind of culture of that, people, that it seemed to be enjoyable in a way, erm, I think I’d find it quite unhelpful” (Rachel, 378-81)
- “So students, I’ve been studying mental health nursing for two years now, it would be handy if I knew how to restrain a patient if I needed to, if there weren’t enough people there. It, it it’s kinda, if, if there was a situation like that, I feel like

I'd be guilty, I'd feel guilty if I had to hold my hands up and say I can't do anything, yeah..." (Cheryl, 152-6)

- "as a healthcare assistant you can restrain someone but as a student you can't so it's like that divide and you can't, as soon as you put your different coloured scrubs on, you're like, as a student you feel a bit like, helpless a little bit." (Cheryl, 267-70)
- "it's going to feel weird, especially if I've worked on the same places that I've been a healthcare assistant, I could back in my [student-coloured] uniform and they go 'oh you can't do that anymore'" (Cheryl, 271-4)
- "cause I think it's probably like a good part of like, learning as well cause some places like they do sort of, they have to do restraints sort of every week so... us watching isn't always enough I guess" (Cheryl, 293-5)
- "I've sort of considered what I would do if I witnessed restraint because I don't know what you do. Um, I, I think I would just document everything that I can and then in my spare time maybe write a statement about like what I think happened and keep it in my personal folder so that if anyone ever questioned me on it I can refer back to it" (Ella, 129-133)
- "I feel that sometimes it's necessary, but, um, I feel like sometimes it's like, it can be avoided. So, I have been on wards where people have started to show violent and aggressive behaviours that I have felt have been preventable by like talking to the patient or using distraction techniques. So, although I haven't watched restraint, I do feel that maybe, erm, a lot of the time it could probably be prevented" (Ella, 139-43)
- [Re: challenging an intervention] "a lot of staff were quite dismissive, so um, I did raise it further like I think it's still in the process of happening, um, but some staff were like oh yeah I agree and they would take it on board but it is, it was the ones who were like complacent in their job and they've dealt with that behaviour for quite a while, they are trying to find the easiest route than the route that would take their time" (Ella, 180-4)
- "As a student, we can't get involved and if I witnessed it, I didn't wanna be a bystander to poor technique, I didn't want to witness someone getting hurt so I thought if I could watch videos or see something then I could say, oh, out your hand by here cause you might be hurting them or something" (Ella, 342-6)

Concerns

- “Obviously it can be quite dangerous, like people do get injured” (Amy, 166-7)
- “I wouldn’t stop, I wouldn’t be able to... I know I’d potentially put people in danger if I did that” (Amy, 230-1)
- “Obviously there’s things involving the Police where people have died because they’re being restrained so it’s potentially very dangerous and I guess from a more selfish point of view if... there’s possibly legal ramifications if something goes wrong or it wasn’t warranted so...” (Nick, 125-8)
- “There’s quite a high risk of getting injured... or... maybe, I don’t know, not doing it until it’s too late or the opposite, feeling you’ve done it without trying enough things before then after you’re like morally, you’re like have I, was it right to do it at that point or did I, like jeopardise the safety of other people because I didn’t do it” (Sarah, 222-6)
- “I think it will, it will be really hard. I think... it... I’d have to really reflect on it, and why it happened sort of, I think you need to remind yourself of why that did happen and not that, it was not a nice thing to go through” (Sarah, 230-2)
- “it’d be hard though... it’s quite, uh, an extreme thing to do” (Sarah, 237)
- “if you think someone... doesn’t want this injection they’re probably thrashing about, they’re not... it’s not an ideal... you know, it’s not an ideal place to give an injection... so I’d be worried about hurting them, getting it in the right place with that amount of movement, you’d have to have, you’d have to really focus and, um, yeah, like a high stress situation” (Sarah, 362-6)
- “the last thing you want to do is hurt the service user in the process of restraining them as it’s an unpleasant experience as it is probably, you’d like to think.” (Molly, 204-6)
- “Sometimes you’re, not out of your depth but cause it’s your first experience it can be quite daunting” (Michael, 52-3)
- “I think it would be quite scary for me, yeah, and it will be a bit... I wouldn’t feel right afterwards, I think I’d feel a bit, I dunno, shaken up, as they will probably [also feel shaken up]” (Simon, 189-190)
- “Harm comes to the service user unnecessarily” (Simon, 166)
- “I would be nervous. I would be quite tense” (Emily, 86)

- “I’d probably respond quite negatively and then I’d probably just get more and more immune to it, just from what I’ve seen from other nurses on the wards” (Emily, 263-5)
- “People with mental health issues can be quite irrational about things like that, and I’ve had experiences before where I’ve done minor things that like wouldn’t be a concern to other people but because they have a lack of insight and a lack of, um, trust in the relationship, they have assumed that I have done something to intentionally hurt them” (Emily, 246-50)
- “I don’t want to do it unnecessarily or in a time when maybe I don’t agree with it” (Emily, 232-3)
- “As somebody who wants to be a nurse, the last thing you want to do is hurt somebody. I don’t want to get hurt myself” (Emily, 229-30)
- “I also think I’m the kind of person who could just freeze up, especially if it’s quite sudden that we need to restrain somebody” (Laura, 192-3)
- “I would probably cower a little bit the first time” (Laura, 17-4)
- “That’s why I think I’d be tentative cause I obviously want to keep myself safe but I also don’t want to be so heavy-handed that I end up hurting the patient” (Laura, 185-6)
- “I hope I never enjoy restraining somebody” (Lucy, 346-7)
- “Cause obviously if their head’s down it could prevent, you know, it could make breathing difficult, and even if, even if, you know, things can go wrong can’t they? With the best will in the world, and hopefully you don’t want that to happen do you? Cause it’s... quite a lot of responsibility isn’t it?” (Rosie, 209-12)
- “There’d have to be a fitness to practice case and an inquest, wouldn’t there? And you know it could just, it could, sorta, really, be a... detriment to your career really after you’ve trained for so long and, you know, something so... preventable, could, you know, end up sorta being life-changing for everyone involved really.” (Rosie, 216-20)
- “I’d hate to accidentally hurt the per-the patient that was being restrained... I’d hate to, you know, for someone to get hurt, like for me to get hurt, or for someone around me, like one of the other patients to get hurt” (Heather, 254-7)

- “We’ve had incidents in the past, in the mental health settings where people have passed out, and, erm, they’re saying “I can’t breathe” but other people take it for granted as they’re joking or they want us to release them” (Freddie, 232-4)
- “There’re consequences, you do it in the wrong way if you are a nurse, your pin is on the line” (Freddie, 135-6)
- “Personally I have concerns... obviously for my own safety first, and the other thing is actively being involved it, it doesn’t really satisfy me as a nurse being always involved in that, actively getting involved in restraints cause that’s not what I’m training to be” (Freddie, 240-3)
- “Guilt in terms of having to having to do that to somebody but also thinking could I have prevented this? could I have done better for this person?” (Rachel, 335-6)
- “I don’t want to hurt anybody... And I don’t want to let anybody else get hurt either whether it’s other patients, whether it’s, er, other staff members” (Rachel, 318-20)
- “I can see the downsides where it could appear dehumanising, I guess. Erm, so... yeah... that’s why I’m maintaining that it’s got to be under the right circumstances otherwise it’s... you could, you could be seen as abusive” (Cheryl, 112-4)
- “Getting injured... if the person has, you know, maybe a weapon or things like that.” (Cheryl, 165-6)
- “I’d probably just feel not great at first” (Cheryl, 222)
- “Maybe if, if there’s lots of staff and everybody comes running, obviously lots of people means more force, I think there’s increased risk so I do worry that like, I might witness restraint that isn’t... er... I don’t know how you say it but like, er, isn’t done well, not like best practice” (Ella, 113-6)
- “I worry that the patient becomes hurt, because I know that they are being hostile and like showing challenging behaviour but that doesn’t mean that they deserve to be hurt. Erm, but also like staff can get hurt in the process, um, there’s legal proceedings... I worry that I would be witness to something that would, um, upset me, and everyone involved would have legal proceedings as well. It’s something that gives me quite a bit of anxiety” (Ella, 120-5)
- “there’s always that risk of harm, and it’s quite a traumatic experience I would imagine being restrained and I guess it’s quite traumatic for staff as well to restrain somebody.” (Ella, 202-4)

- “I worry because you’re relying on other people... When I become qualified I’ll be relying on other people to give me that information, um, I worry that I’d miss out on something, so, um because I don’t know lots now I worry that I’ll qualify and still not know a lot about it” (Ella, 223-6)
- “I’m quite aware that it’s quite short training, um, so I worry that I’ll miss things out or I won’t know about certain things and then I’ll get in trouble for those” (227-9)
- “Mostly concerns that I would hurt the person unintentionally, or that I might be forced into a position where, if, um, in an environment where it is quite complacent or if there’s... say there’s larger men involved where there’s a fragile patient possibly hurting somebody under pressure, like, feeling like I have to do a certain way cause in the time you don’t have time to think or say oh sorry I don’t think that’s quite right you just have to act so I do worry that in the moment that something could go wrong that I can’t necessarily control” (Ella, 250-6)
- “I know there’s a lot of legal consequences and it might cause tension within the work environment but for me my biggest concern would be hurting the patient” (Ella, 260-1)

Relationships

Sub-theme: Service users

- “If they see you as someone who’s going to try and hurt them, how is that, how are they going to trust you again?” (Amy, 165-6)
- “I think that could be really damaging. If you lose trust then they’re not as likely to open up to you and that, and to accept what you say” (Amy, 248-9)
- “It’s almost put them a step back cause they’ve like, gone withdrawn” (Amy, 263-4)
- “Just have to leave them for a while, a couple of days even. Just let them deal with it on their own and let them come back.” (Amy, 270-1)
- “Oh god... well... I’d probably be really apologetic and try and explain why I thought we had to do it and probably try and also explain that I understand why you’d be really, or why the person would be really angry or upset about it.” (Nick, 187-9)
- “It’s hard to... like rekindle that relationship after that’s happened, like after someone has been you know, restrained or, um, you know, injected with

medication against their will, it's, it's horrible. It's hard for them to be able to trust the staff again after so it's, it is like a step back" (Sarah, 128-31)

- "Talk to the patient, like they're the one this happened to, like see where they're feeling after and try and work through with them why that happened so they can, so there's hopefully a chance of, um, of having a therapeutic relationship with them again, that would be the main thing... the patient" (Sarah 232-6)
- "It's very invasive, so they'd probably have their guard... they probably wouldn't wanna have anything to do with you, so you'd just... and again it's not pushing people if you've been clearly told 'look I don't wanna talk right now' then respect that, like, let them have their time, I think... Um. And then try and come back once they've had that time" (Sarah, 274-8)
- "depending on the service user obviously, but mostly it would have a negative impact... Say they're in seclusion or they've been IV-ed and they've been knocked out for a few hours they probably look at you like 'you've done this to me, you've taken my control of my own self away' which is a horrible thought to have but also I guess it's about being honest with the service user as well... saying why this has happened, why it got to that point... keeping that trust there because sometimes it is needed if they are a danger... to themselves or others... so it's really talking to them about that and how I understand that it's not a nice feeling but, and then say why I think, why it got to that point" (Molly, 224-32)
- "It can be very traumatic and it can be a bad experience for that person and if you've built up a good rapport with them it could like diminish" (Michael, 259-261)
- "I'd go on as normal really and say, just... bounce off, bounce off whatever they're saying" (Michael, 267-8)
- "I think communication's key – keep everyone in the loop and speak to the patient too, not to just pretend like nothing's happened" (Michael, 303-4)
- "I wanna say be apologetic but you can't because it was a professional thing so I think it's sorta showing them that you did that from a place of care that you were trying to keep them and other people safe" (Simon, 210-2)
- "I've always thought of building a therapeutic alliance as sorta like a ladder [gestures climbing the rungs of the ladder] and when you've done that you've gone down a few steps on that ladder and you're gunna have to, with time, go back up on that ladder" (Simon, 217-220)

- “Sitting down with them and telling them, in total transparency really, why you did that, why it was necessary and how, even saying, I didn’t enjoy doing that to you, I’d rather not do it again, let’s work on some things we can do to prevent that” (Simon, 225-7)
- “I think it would... break down that therapeutic alliance you’ve built with them. Cause, yeah I have witnessed nurses have a really good relationship with a service user and then afterwards it’s... after a restraint it’s not the same” (Simon, 202-4)
- “It depends on if they remember it, you know, some people won’t remember it because of really poor mental health and so they will just block out certain things that happen or, like, they might remember the feeling, but not know why they feel so, um, upset, and so, violated” (Emily, 309-12)
- “It depends on the patient, how long it took for them to like, acclimatise to what had happened” (Emily, 327-8)
- “I think... maybe once the rapport with the patient got better I would maybe feel better about myself knowing that they were okay” (Emily, 303-4)
- “I would hope that the relationship, like if I could sit down and talk with them about why it happened, you know, that would be better for their patient care as well in terms of being person centred and them always being involved, you know *‘nothing about me, without me’*” (Emily, 312-5)
- “Give them time afterwards, give them space” (Emily, 322)
- “Maybe give them some sort of small task or things or play a game, things that aren’t, thing’s that don’t focus on, er, their care plan because they might not want to get into that first” (Emily, 323-5)
- “You’re just going to end up with a nasty relationship with the patient” (Laura, 136-7)
- “I do worry about how you have a therapeutic relationship with someone who you’ve just had to restrain” (Lucy, 243-4)
- “On admission, you know, talk to the patients and explain that, on occasion, con-, you know restraint is used and what way it’s used and that it’s not used as a personal... attack on anybody and that it’s there for their safety and for the safety of others. And what that meant was that they could then go back and have a debrief with the patient” (Lucy, 276-80)

- “That meant their therapeutic relationship could... start, um, it could continue after that point because they’d had that honesty” (Lucy, 282-4)
- “You have to go in and treat them with respect still” (Lucy, 296-7)
- “I think you might still be wary, maybe you will be a bit more conscious and that’s what I mean, you have to try and not change your approach to people because you’ve restrained people and I think that’s hard” (Lucy, 302-5)
- “I’d be concerned about the service user, I think that would be the first thought at all times, erm, so are they okay? Are they... what’s happening with them really, that would be my first, you know, like, my first priority would be them” (Rosie, 234-6)
- “You know it could be a negative but they, I suppose it would depend on their state of mind at the time, they might not even, they might be aware of it” (Rosie, 264-6)
- “Hopefully you’ll be able to resolve it in a few days, but you might not, you might just not get back to a good therapeutic, you know, relationship” (Rosie, 281-2)
- “Depending on capacity I would probably, hopefully... try and talk to them about it, depending on, you know, how they were, and it depends again on their state of mind, or how they were reacting to you” (Rosie, 267-70)
- “If they’re sorta a bit hostile towards you you’re probably better just giving them a bit of... a wide berth really” (Rosie, 275-7)
- “If you spent so long building up a trusting relationship with them and then, in that split second it’s gone” (Heather, 259-61)
- “I don’t know how the conversation will go, but I’d like to see how they are, erm, see what their understanding was of the situation and if they’re in a place maybe to have that conversation, erm, see if... see if they can see why it happened, let them talk about what they thought about it, and how they feel now and almost help them process what happened” (Heather, 300-4)
- “From the patient’s point of view, some of them they think they’re being held, erm, unfairly so they think we’re awful after the intervention, after that they feel embarrassed in front of their other patients, other peers, they feel like they’ve been violated” (Freddie, 163-6)

- “I want to have a therapeutic relationship between me and my patient, so that’s the only way to make a positive difference and to help them make, get better, to where they’re supposed to be” (Freddie, 246-8)
- “You find a patient who doesn’t like a particular nurse because that particular nurse every time they are on shift, they were restraining her, or restraining him” (Freddie, 329-31)
- “That’s one of the things that, there’s that line that you don’t want to cross but at the same time, if you sit down after restraint and have a debrief with the patient and say “Do you know why we did this? How can we help you next time to avoid this?”” (Freddie, 201-4)
- “You’re saying “I apologise I did this but at the time you need to take control of your emotions”” (Freddie, 204-5)
- “Personally I would want to sit with my patients and say look, we do not want to do this, we explain before the restraint if you do this, for, for your safety and the safety of others we will have to do this” (Freddie, 333-6)
- “The experience of peo- of service users who’ve been restrained, especially being given medication who have had experiences with sexual abuse and sexual assault I think it’s especially important to try and avoid with them, but also to be with them through that process and those, those service users in particular might need, might need a bit of extra support afterwards” (Rachel, 408-12)
- “It’s really damaging you’ve built up that relationship and if you’re the person stood there giving them an injection they don’t want or holding them down in a way that they don’t want they’re not gunna wanna talk to you that much, they’re not gunna trust you anymore” (Rachel, 302-5)
- “I think I’d be kind of mourning that relationship that I was kind of thinking it’s not going to be there anymore it’s not going to be the same” (Rachel, 340-1)
- “You just become the abuser and the bully in that situation” (Rachel, 413-4)
- “We also have to be honest with patients in the part of the role that we play because they, know they’re not silly they know that we that we’ve kind of drawn up like that medication they know that we know what’s going to happen to them so we have to be honest about that” (Rachel, 310-3)

- “If you’re kinda more open and honest and kinda with them through that process rather than just restraining and go it’s more likely to damage control essentially with that relationship” (Rachel, 405-7)
- “Let’s say you’re building up a really good rapport with the person, and then you’d, they’d had an episode where you’d had to restrain them, that person would most definitely look at you differently, and say ‘oh my goodness, this nurse has done that to me, maybe I can’t trust her” you know?” (Cheryl, 135-8)
- “I really like, value my relationship with the patients and like, this... the thing about trying to have a therapeutic relationship but then... to me, like, if you were to restrain someone, I feel like that would be quite a big barrier to a therapeutic relationship, like, it could, I feel like it could either cut off the relationship completely, or just like make things awkward” (Cheryl, 172-6)
- “I would probably approach them, quite slowly and like on their terms” (Cheryl, 180)
- “You spend so much time establishing trust with that person and developing that professional relationship and it can be made so fragile in that moment anyway so then to further hurt them would be quite, I’d find that really upsetting” (Ella, 262-5)
- “They might not trust me or they might feel that I’m just going to do things whether they like it or not cause in that moment they don’t have a choice of what’s going to happen, so I do worry that they would stop talking to me, and stop, erm, like, maybe complying with medication cause they think like they have a bit of like bitterness toward you” (Ella, 270-4)
- “It’s really worthwhile after having a restraint maybe sitting down with the patient at least like you and another member of staff or somebody else who was involved in the restraint and explaining why you restrained them, what they did and the consequences of that and how it could be better managed, and saying how they how feel in that situation, how could they manage it better in the future and then updating their care plan to reflect that so other people are aware” (Ella, 278-83)

Sub-theme: Colleagues

- “I’d be worried that if I didn’t do it properly that everyone would be like criticise me really quickly” (Amy, 277-8)

- “If I didn’t do it properly, they’d be like ‘oh yeah she did it wrong’ and then you’d have that sort of... nurses being clique-y, like, I was like the ‘other’ and that I was removed somehow” (Amy, 278-280)
- “I think on wards that do restraint, I’m sure that there’s a culture where the staff are, they’re a team, and they would work together and I think that if you challenge a call for a restraint that would cause problems um, or vice versa if you thought there should be a restraint and people didn’t, that could cause problems, so I think yeah there’s potential in terms of people not agreeing on what the right course of action is” (Nick, 194-9)
- “I’d like to think we’d be kinda on the same wave-length with our... with why did that happen, like why did that have to happen?” (Sarah 286-8)
- “Maybe if a restraint goes wrong, that can be very detrimental because someone could be blaming the other person, etc, or maybe just in the sense that it can be distressing if people don’t talk about it, then it probably leads to stress in the workplace, people taking it out on each other. It can lead to a lot of things probably” (Molly, 266-9)
- “I think some people... are more okay with restraint, and some people aren’t so there can be different opinions and I think, you can work through those differences, but again it takes time [laughs] but we don’t always have that” (Simon, 235-8)
- “Teamwork’s about knowing your team, knowing your colleagues and working efficiently together” (Michael, 275-6)
- “Teamwork’s really important in that so if someone makes one mistake it could, it could affect another member of staff, they could get a punch in the face...” (Michael, 274-5)
- “There will have been colleagues who have done it before so they might be able to sympathise with how I feel, and there might be other colleagues who have never done it who are wanting to ask me about how it was so that sort of sharing the experience would hopefully” (Emily, 334-7)
- “I hope it wouldn’t affect it because... there would be a shared understanding between us all about why it would be done” (Emily, 333-4)
- “I think it would probably bring us closer together, especially if it’s quite traumatic, I’d like to think that people would probably try to help” (Laura, 250-2)

- “If they just focused on the failings of the whole thing then that would obviously make me feel worse about the situation” (Laura, 269-70)
- “It depends on the colleagues... I’ve found certainly in mental health everybody tries to be really supportive of each other” (Laura, 247-8)
- “I think where this can be negative is when you don’t all believe that you got to the point in the right way or that things were carried out in the right way and if that isn’t discussed openly then that can create tension and animosity” (Lucy, 313-5)
- “I think it’s all about communication both with the patient and the team, and I think if you can communicate about how and why and about how people felt... then, then that’s positive, but if you don’t and you just carry on and don’t acknowledge it then that can, can cause issues.” (Lucy, 320-3)
- “If it went wrong then, you know if, if someone got hurt then that might cause a bit of friction between staff” (Heather, 320-1)
- “Sometimes teams can be a bit clique-y can’t they? And erm, that can make it difficult to go to someone in that team” (Heather, 330-1)
- “Cause we’re working as a team, and we’re doing something together, er, we’ll be communicating with each other so it’ll strengthen our, how we work together as a team” (Heather, 311-3)
- “If you were that kind of nurse who is not always getting involved in restraint or will not help out if there’s a restraint people will say “She doesn’t help out... he doesn’t help out... he’s not supporting us, he’s not..” so they may you feel like you are not supporting them, and in an actual sense if you do not want to get involved in that thing, you are not a team player” (Freddie, 369-73)
- “I think people like it when you support them, if you support them in areas like that, they enjoy it. It’s kind of bringing the bunch together” (Freddie, 367-8)
- “You work as a team, you support each other and make, er, each other feel valued then they are part of the team, you are working together” (Freddie, 374-6)
- “If something was to go wrong, it could break that trust in that, if something like that was to happen again, you know, it can kinda split, split you quite a bit” (Rachel, 439-40).
- “If you’ve got a team where the culture is... eager to kind of be doing that kind of thing it means that you’re gunna be less willing... I think it could lead to, again,

resentment toward those team members which means that you're not gonna work very well together" (Rachel, 446-9)

- "So if everything went to plan and things like that I think, I think it can promote that kind of trust in each other" (Rachel, 436-7)
- "I've heard that it makes a team stronger, and they kinda like help each other, hopefully, on the right, right environments, they help each other and they support each other, and debrief and things like that, make sure everyone feels... some sort of closure at the end of what's just happened" (Cheryl, 195-8)
- "if the restraint goes well it would strengthen your relationship because you've all, um, got something in common, you've all shared a, like, not very nice experience, um, and when you discuss that with somebody obviously you're talking about something quite personal" (Ella, 288-91)
- "I do think that if I felt uncomfortable with how somebody else managed it or handled it, um, it would cause quite a lot of tension and I think that's quite difficult and makes fragile relationships with colleagues which obviously can affect your work" (Ella, 291-4)

Post-incident support

Sub-theme: Helpful

- "Advice can be needed and it's important but maybe I just need someone to listen to me first" (Amy, 346-7)
- "That would probably be quite good, like if it was enforced, if everyone had to do clinical supervision I think it would be helpful in general because it can be quite difficult, regardless of any of this" (Amy, 355-7)
- "Talking verbally about it, so like everyone gets a say in it, like maybe going, maybe talking to like, a different party who wasn't actually there so they're unbiased so you can maybe writing things down, like putting thoughts and feelings out there and looking at how we can avoid that happening next time" (Sarah 251-4)
- "I think you'd definitely need some sort of debrief from someone who is... yeah... probably be a manager. Um... but yeah I think support is important" (Sarah, 295-7)

- “As a qualified nurse I’d probably want the team and people around you who probably haven’t been involved in restraint are probably a strong source of support cause they don’t have the... overview of like, ‘I’ve been through that...’ or you know, if they’re less understanding of it they can probably really sympathise with how horrible it might be” (Molly, 282-6)
- “You need people that are compassionate to what you’re... how you react to something. So say I react to something really emotionally, and someone reacts to something and they don’t, it doesn’t affect them much, you still need that person to understand why you’ve reacted in that way, I think that’s really, that’s an important part of being a strong team, you’re not judging someone for how they’re reacting to a specific situation... And also you need strong characters in a team to guide, guide people so in one team, on one shift, you probably need someone to really take the team and carry them through, like, each event, I think that’s the best thing is compassion, understanding what people are going through and why they react in that way... because one thing to one person might be nothing, but to the other person it might mean the world” (Molly, 312-22)
- “I’m not sure if they talk amongst the staff about it, maybe that would be a good idea to sort of debrief” (Michael, 252-3)
- “Make it open, if someone wants to reflect on what went well, what went bad, how they felt” (Michael, 291-2)
- “I think one person might need to have one to one cause they might not really be able to say, sort, stuff, stuff in a group, but in one to one, everything can come out” (Michael, 296-8)
- “Helpful support would be understanding from my colleagues” (Simon, 271)
- “Debriefs afterwards... I do like to sit down when I’ve, sit down when I’ve seen restraint, I like to sit down when they have that little debrief and see what could’ve been done to prevent that sorta from happening” (Simon, 194-6)
- “If I was guilt-ridden and I just thought no I can’t believe I’ve done that and it wasn’t for me, I’d, um, seek help from the ward manager to see what they say because I can’t have been the first person to have ever felt like that so, my guess is it’s quite common seeing as I’m not supposed, well not supposed, but I guess nurses aren’t driven into nursing by thinking ‘oh I get to do restraint’” (Emily, 349-54)

- “My go-to for me is to just always call a family member to debrief myself, I know I’d want that debrief with somebody, even like talking to a nursing peer about it, you know another student or another nurse when I’m qualified in terms of saying ‘how did you feel when it happened to you?’ cause I’ve been feeling like this” (Emily, 299-303)
- “There was debriefs about why certain interventions were used amongst, like, the multi-disciplinary team, um, the patient wouldn’t be present, it would be nice if the patient could be present but I understand that in some cases that can’t be possible, but yeah, just discussing why it might be the right option” (Emily, 345-8)
- “I think I would need that space to talk with someone, that reassurance that even if I did freeze that, like, the next time, I’d be fine” (Laura, 258-60)
- “If I couldn’t debrief with the rest of my staff members, I’d probably have to do it with anyone either at home with my boyfriend, or if I messaged my other nursing buddies” (Laura, 208-10)
- “I think I’d need to talk it out if I was shaken up by it to be honest” (Laura, 213-4)
- “If it was quite physically and emotionally distressing I think that, I’d do it, but then afterwards I’d need a bit of a debrief with someone to talk through what what happened and things cause I think I would probably struggle with it” (Laura, 174-7)
- “Understand how it can inform our future practice so it doesn’t just become a, “Is everyone alright?” you know, “Alright he’s safe, we’re safe, they’re safe let’s move on” you know, as, as long as it’s meaningful and meaningfully informs future practice I think, sort of, reflective in nature” (Lucy, 338-341)
- “I think debrief is really important. And I think that awareness of not becoming institutionalised, you know, of it becoming a habit, and really being conscious of everything you do” (Lucy, 254-6)
- “Provided, you know, you’d restrained someone, then they got what they needed and hopefully the situation calmed down, you might just need a little decompress” (Rosie, 306-8)
- “You might just go home and you might just say “I need a bath, and I just need to go watch a film” and you know “Don’t talk to me” [laughs] or it might be “I just want a cuddle” or whatever” (Rosie, 353-5)

- “You’d have to talk to your, er, er, your other colleagues really wouldn’t you? A bit... I think, that’s what supervision and things are there for isn’t it?” (Rosie, 257-9)
- “You have got sorta, managers that would do supervision or you could go to, or you know, if you felt that you needed more training or more information hopefully you could, you know, make sure that you know that you got that support you needed” (Rosie, 299-302)
- “I presume there is paperwork to do isn’t there and I suppose you’d have to put it in your notes or whatever so, I suppose as you’re doing things like that, it... then the understanding or the sorta rationale behind it probably make more, makes sense in your head” (Rosie, 313-7)
- “You should have somewhere to go and someone to just talk this through and just to like, not, erm, not to explore how you’re feeling but just to process it all” (Heather, 344-6)
- “I feel like you would need a bit of a debrief, like a bit of a talk with someone, you know like supervision” (Heather, 341-2)
- “It can be quite an emotional thing if you’re involved in something like that, erm, but I would be happy as well with some sort of group situation where everyone just talks through how it went, erm, what could, what went well, what could be done better” (Heather, 357-60)
- “Manager’s support, it’s good to have your managers speaking to you and explaining, try to, kind of... motivate you or encourage you or thank you or helping you to boost your morale” (Freddie, 392-4)
- “The support we get from our managers or the people above us is what keeps us going, working as a team is what keeps us going, if you feel valued, you find some areas they are gelling as a team and they’re working together, supporting each other from top to bottom, that area, you don’t find many instances of people restraining people” (Freddie, 403-7)
- “When I get home, I’ll often go to the gym, I, I, that’s my stress buster really” (Freddie, 316)
- “If we have a debrief at work, normally after that restraint it’s the handover bit, that’s when we reflect a bit, on how we did the day, how things went and how we could have done better in some areas” (Freddie, 308-11)

- “When you get that chance of having a debrief it’s important to talk about things like that, to reflect, and see how you did things, and how better, how best you could have done them” (Freddie, 313-5)
- “It’s a small debrief but someone senior to you, it would be nice to come to you, and appreciate what you do cause in nursing if you don’t get appreciated by the people senior to you, you a, you as a nurse don’t feel like you are valued” (Freddie, 396-99)
- “If it’s available, probably clinical supervision would be best” (Rachel, 350)
- “[family] reassurance is quite important, reassurance from colleagues at University” (Rachel, 353)
- “I think being able to talk about it and also reassurance of, okay... so this is what, going back over the situation and so this is this is what happened this is what we did this is what we did here and like going through it and kind of pointing out that yes we did this right but then also kind of how to improve on that ne- for next time” (Rachel, 363-6)
- “Yeah, I think like group debriefing and like, um... sort of... taking it, taking a bit of time away from the patients and like, like together and doing something nice as a team, that would, that would probably help, like, strengthen the bond in the team and, sort of, like, provide a bit of like happiness” (Cheryl, 235-8)
- “Possibly the next day I might speak to like my manager or somebody within the work environment and explain that I did feel like, oh, it upset me afterwards and see if you can just chat about it.” (Ella, 243-6)
- “A debrief is really beneficial and sort of discussing what went well, what didn’t go so well, and all sort of like consolidating your knowledge on the situation and then if anybody feels uncomfortable, um, I, you know for me I’d quite like to like sit down with somebody and make sure that the technique that I used was the best that it could be” (Ella, 316-20)

Sub-theme: Unhelpful

- “I wouldn’t put myself forward for it [support] cause I wouldn’t see it as serious and I think maybe that’s a me problem but I think a lot of people have it where they would thing ‘oh no this isn’t, this isn’t important enough. I won’t try and access that help even if I need it” (Amy, 365-9)

- “Where people who work in it are probably a bit desensitised... So as your first one you might think ‘oh my god’, someone who’s done it a thousand times will be ‘it’s fine’... yeah, it just happens.” (Molly, 286-9)
- “Unhelpful support would be like ‘you should not have done that, it was totally wrong, we should have done it this way’” (Simon, 272-3)
- “People [being] too overprotective, um, and, completely remove me from the situation you know, everyone has hurdles that they have to get over and I think if this was something where I was feeling a bit unsure about what happened and I wasn’t really sure where to go with it, there’s only so much help people can give you, sometimes you have to get there on your own” (Emily, 371-5)
- “If the staff happens to be more negative about the situation that wouldn’t be helpful either” (Laura, 268-9)
- “If you’re ever kinda mocked or told off for feeling sensitive about it, that would be unhelpful, you know that whole “Just get on with it” approach... ‘Man up’ should you use that horrible term...” (Lucy, 347-9)
- “Someone being a bit negative and saying ‘Oh well, just deal with it’ or something like that” (Rosie, 326-7)
- “If, if no-one really talked about it afterwards and there wasn’t any space to learn from it” (Heather, 365-6)
- “If I didn’t have anyone to talk to afterwards that wouldn’t be very good I’d be quite worried if that was how it would be like” (Heather, 369-71)
- “The idea of like “Oh get over it, it’s part of your job” sort of thing you know? Go home, forget about it sort of thing, you know, or it’s just mental health” (Rachel, 375-7)
- “I guess the most unhelpful type of support would be no support” (Cheryl, 243)

Reality check

- “Well, I mean, in a perfect world, er, you’d work with, if you were new, you’d work with people who are experienced and they’d also be really good and competent and nice and you could talk about what had happened and whether it was the right decision and you could disagree and it wouldn’t be a problem” (Nick, 204-8)
- “Hopefully it wouldn’t be easy for, um, for anyone, for any of the staff to do, um, we’d just speak about it after I guess.” (Sarah, 289-90)

- “I know there’s some teams that probably will be like “this happens, lets not talk about it, it’s happened” because it happens all the time, where some teams and nurses will be supportive and understand that that’s quite a distressing thing to experience for the first time” (Molly, 294-7)
- “I’m not very confident that it’s there really because it’s very rare that there is supervision or debriefs afterwards just because there is no time or... staff availability for those to occur” (Simon, 279-281)
- “We’ve been told that we should always debrief after an incident, but, um obviously with the way staffing is in the NHS certainly, it doesn’t always happen” (Laura, 207-8)
- “I think everybody should always have a debrief and I haven’t seen that happen that often. Erm, because, this is where I’m talking about it being accepted as a cultural norm and actually if you do debrief and you do... talk about it as something which is outside of the norm it highlights that” (Lucy, 327-30)
- “I don’t think any nurse goes into this job to want to restrain people and to not want to support their colleagues but our wards are so short-staffed and people are so... under pressure that things that aren’t urgent and essential don’t get done” (Lucy, 353-6)
- “You’d sorta be aware of the team around you, that you’d all play a role in it and be as supportive as you could and hopefully, you know, it wouldn’t be for long, I’m presuming there’s time limits on these things, so hopefully, you know, it would, it would hopefully... resolve itself... quickly” (Rosie, 226-9)
- “I think it can be quite difficult because of time for the manager to speak to every single person involved on a one-to-one” (Heather, 355-7)
- “I kind of feel like there probably isn’t as much support available as I would like, erm, because... everyone’s just so busy and I feel like with things like that it just happens and then everyone just gets on with their day” (Heather, 376-8)
- “In an ideal world [laughs] there would just be no restraint and I kinda see it going that way, I think they are trying to reduce it a lot” (Heather 197-8)
- “Not all places have that time to have a debrief, because, as I’m sure you’re aware, mental health services are so short-staffed, they’re under-staffed and, and under a lot of pressure so getting a time for debrief is so rare” (Freddie, 311-3)
- “I don’t feel particularly confident that the support is there” (Ella, 324)