Lost without Translation

Understanding restrictive intervention management for

people with dementia in a mental health setting:

An interpretive description

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I declare that this thesis is my own work and has not been submitted for the award of a higher degree elsewhere

Abstract

Lost without translation. Understanding restrictive intervention management for people with dementia in a mental health setting: An interpretive description

Background: Dementia is characterised by a set of symptoms that affect the functioning of the brain. It is estimated that there are 850,000 people living with dementia in the UK and 46 million people worldwide – more than 60% of whom are women. In the UK, approximately one third of people with dementia live in care settings where staff may apply restrictive interventions guided by legislative frameworks.

Aim: To understand the management of restrictive intervention practice by mental health workers in an acute mental health setting for people with dementia.

Methods: An interpretive descriptive study was undertaken. Vignettes were developed using evidence based literature, case law and practice guidance and used to frame semi-structured interviews. Mental health workers and practice leaders were purposively sampled and interviewed from an English NHS Foundation Trust which provides mental health services across two counties. Thematic analysis of data was undertaken which followed six phases and utilised NVIVO-10.

Results: Four key themes were identified: 1) legislation, 2) policy, 3) training and supervision and 4) person-centred restrictive intervention practice.

Discussion: Practice leaders are able to translate knowledge from legislation to frame restrictive intervention policy, practice guidance and training content for mental health workers. Mental health workers can then deliver restrictive intervention practice based on person-centred care principles although specific characteristics such as gender may not be acknowledged as shaping a person's experience of dementia. A 'Model of Translated Ways of Knowing' was developed that demonstrates the knowledge journey from legislation to practice.

Conclusions: Restrictive intervention practice can be enabled when legislation, case law, research and national policy are translated into an accessible format for mental health workers. Translated knowledge can then facilitate person-centred restrictive interventions for people with dementia.

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Chapter One: Introduction and Background

1.1 Introduction

My interest in restrictive intervention management for people with dementia stems from my own practice experience of working in complex care environments with little clear guidance on how to act. In recent years, legislation and evidence has been developed to inform practice, seeking to protect both people with dementia and the staff that work with them. Anecdotally, these developments have introduced further complexity and confusion into practice settings where the numbers of people with dementia continue to grow, year on year (Alzheimers Society, 2012). The core aim of this piece of research was to understand how mental health workers are currently managing restrictive interventions to inform care environments and stimulate further exploration.

In 2009, the National Dementia Strategy sought to frame the dementia policy context for the UK, galvanising interest and support to address the unprecedented care and treatment agenda that dementia incidence and prevalence is expected to bring (the Alzheimer's Society estimates that by 2050 more than 2 million people in the UK will have dementia). The strategy was followed by the Prime Minister's Challenge documents (2012, 2015) which set out key priorities deemed to be essential if the UK is to successfully manage assessment, care and treatment for the predicted number of people with dementia. The priorities include a need for dementia friendly communities and a workforce that has the key knowledge and skills to support people with dementia and their carers.

Training the workforce is acknowledged as a complex and significant issue (Hussain and Manthorpe, 2012). The number of people expected to live with dementia means that the formal (employed, rather than informal or family carers) dementia care workforce is large and diverse and will have differing needs and abilities in terms of training and the acquisition of knowledge. Some areas of dementia care practice are particularly challenging and require a sound understanding of policy and law: the delivery of restrictive interventions for people with dementia is one such area.

Restrictive intervention practice (sometimes referred to as restraint) for the non-consensual care and treatment of people with dementia in England and Wales is governed by two legal frameworks which operate in parallel – the Mental Health Act (MHA, 2007) and the Mental Capacity Act (MCA, 2005). The MHA provides legal authority for mental health assessment and treatment in relation to the protection of the public and the service user. The MCA provides the legal framework for acting and making decisions for and on behalf of adults who lack mental capacity. The MCA (2005) also provides the framework for applying restrictions and restraint where this is necessary and proportionate in a person's best interests, in circumstances where a person lacks capacity. In law, a distinction is made between restriction and the deprivation of liberty, and the MCA (2005) stops short of providing the legal authority to deprive a person of their liberty.

The Deprivation of Liberty Safeguards (DoLS) came into force in 2009 as a supplement to the Mental Capacity Act (this supplement was introduced at the same time as amendments were made to the MHA). The DoLS legislation aims to ensure that adults who lack capacity to consent to being in a hospital or care home are only deprived of liberty if it is in their best interests and necessary and proportionate to

potential harm. The relationship and overlap between the DoLS (2007) and the MHA (2007) is acknowledged as being complex (House of Lords, 2014). When case law, research findings, diverse opinion and interpretation are added, the degree of practice uncertainty can be significant.

The complexity of the legislation when considering the application of restriction and restraint provides a considerable challenge to mental health workers in dementia care and treatment environments, where people with dementia often lack capacity to consent to admission to hospital or to receiving personal care and or medical treatment. Mental health workers are required to practice in this environment on a daily basis, making judgements and decisions about the appropriateness and degree of restrictions to facilitate care and treatment – and which also comply with the law.

1.2 Background: Definitions and Key Concepts

1.2.1 Dementia

Defining dementia is complex as it requires pulling together a consensus across evidence and opinion. It is characterised by a number of symptoms which affect the brain and is caused by a number of disease processes with Alzheimer's disease being the most prevalent (Alzheimer's Society, 2012; Dementia UK, 2007; World Health Organisation, 1992).   Dementia is usually experienced as a progressively disabling process and is likely to limit life expectancy, with most people dying three to eight years after the onset of the disease (De Bellis et al. 2011; Xie et al. 2008). The causes of dementia are multiple: some are preventable such as the effects of smoking and obesity, and some are treatable such as cognitive symptoms which may respond to cholinesterase inhibitors (Livingstone et al. 2017). It may also be argued that dementia is a gendered issue: globally, more than 60% of older people are women and as age is a significant risk factor for dementia, women are

disproportionately affected. Additionally, women are more likely to be informal or formal (employed) carers for people with dementia than men - more than 80% of formal care workers are women (Alzheimer's Disease International, 2015; DEEP, 2015).

In recent decades dementia care and treatment has been advanced by a person-centred movement which has sought to de-medicalise the experience and societal view of dementia. The ground-breaking work of Tom Kitwood (Kitwood, 1997) has been further developed in recent years by researchers and mental health workers determined to promote and influence person-centred approaches (May et al. 2009). There is a significant body of research evidence, clinical opinion and interpretation in relation to dementia which drives treatment advances and the policy context. The National Dementia Strategy (2009) and subsequently the Prime Minister's Challenge 2020 (2015) represent the fundamental plan to address demographic implications of an aging population. The plan is committed to improving rates of dementia diagnosis, enabling more people to live at home for longer and championing the notion of living well with dementia. However, some people with dementia will not be able to remain at home and will spend periods of time in care environments, including mental health hospital settings. During these periods, they will be supported by health mental health workers who may utilise restrictive intervention approaches which are designed to enable the safety and wellbeing of people with dementia, their carers and others.

1.2.2 Restrictive interventions

Interpretations of restraint, sometimes described as restrictive interventions, differ across the literature and policy guidance (in this thesis document, both terms will be

used interchangeably). In adult mental health, the National Institute for Health and Care Excellence (NICE) published guidance in 2015 for healthcare professionals, service users and families to manage violence and aggression. This guidance pulls together the evidence available and makes recommendations about the use of restrictive interventions. For adults with a cognitive or learning disability, concerns have been highlighted in recent years in the UK by investigations into poor practice and abuse, in particular the Winterbourne View Hospital investigation (Dept of Health, 2014). In terms of the legal framework for restrictive intervention practice, as previously stated, the MCA (2005) was implemented in 2007 and later supplemented by DoLS (2009). Section 6 of the MCA (2005) specifically outlines how restrictions can be applied and DoLS (2009) structures the process necessary when restriction is applied to a degree which constitutes a deprivation of liberty.

The evidence base related to the care and treatment of people with dementia is vast but there is significantly less research which is related to providing care and treatment in the context of the application of restrictive interventions (Dept of Health, 2014; NICE, 2007; Mohler et al. 2011; Riahi et al. 2016). Evidence which specifically explores the experiences of staff (when applying restrictions in practice) is more limited still, but policy guidance suggests that training and supervision enable learning and support least restrictive practice to be maintained. It further suggests that frontline staff still struggle to understand and articulate the theoretical and legal frameworks which govern practice (Dept of Health, 2014). Despite Government intervention to strengthen the legal platform which governs practice by introducing the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (2007), research, audit and inspection suggest that in care and treatment environments, this often does not directly inform care planning for people with dementia.

A Cochrane review of physical restraint literature (Mohler et al. 2011) identified definitions ranging from specific interventions that inhibit a person's physical movement to more generic descriptions of any restriction or restraint which limits freedom of movement. More recently the Department of Health published guidance titled, Positive and Proactive Care: reducing the need for restrictive interventions (2014). This guidance also uses the terms restriction and restraint interchangeably and clearly defines physical, mechanical and chemical restraint with seclusion and long-term segregation as means of restrictive interventions in exceptional circumstances (Table 1.2). Notably these terms relate to the UK only, as definitions across other countries differ in the context of local practice and legal frameworks.

Table 1.1: Types of restraint and restriction

Type of restraint or restriction	Definition
Physical restraint	Direct physical contact where the intervener's intention is to prevent or restrict a person (eg: one or more people holding or restricting the movement of a person's body).
Mechanical restraint	The use of a device to prevent, restrict or subdue movement of a person's body (eg: bed rails, door locks, clothing that is difficult to remove).
Chemical restraint	The use of medication which is prescribed and administered for the purpose of controlling and subduing.
Seclusion and long-term segregation	A restrictive intervention in exceptional circumstances – supervised confinement and isolation of a person.

Currently, the Positive and Proactive Care (2014) document and UK policy frameworks do not address the issue of surveillance technology as a form of restriction. As technology improves and the number of people with dementia grows, it seems likely that technology as an enabler and technology as a restriction for people with dementia will be reviewed. The Positive and Proactive Care (2014) publication is a key document as it brings together evidence and policy guidance which was collated over the decade prior to publication, to promote cultural change within care delivery settings to support safety and promote the recovery of service users (Francke & Graaff, 2012; Goethals et al. 2013; HM Govt, 2014; McCabe et al. 2011; NICE, 2005; DoH, 2008; Skills for Care and Health, 2014).   This guidance also reiterates the importance of the MCA (2005) as a fundamental piece of legislation in relation to people with dementia. Many people with dementia who receive care and treatment in acute mental health settings will lack capacity in a number of decision making areas: the MCA (2005) ensures that there is a framework which outlines a process for those who lack capacity to be safeguarded. The MCA structure sets out how restrictive interventions are to be made in a person's best interest and identifies, as a principle, that interventions are to be as least restrictive as possible.

1.2.3 The legal frameworks

As described previously, in 2013 The House of Lords commissioned a select committee to review the progress of the MCA (2005) and DoLS procedures (2009) in practice. The central message to the Government was a need to improve the implementation of the MCA (2005) and to review DoLS (2009) given the poor level of knowledge and understanding within the healthcare workforce. The Government's response in June 2014 (Valuing Every Voice, Respecting Every Right) outlined an

intention to retain both the MCA (2005) and DoLS (2009) with simplified application of the latter.

However, following further consultation in 2015 and 2016, the Law Commission issued a draft bill to parliament (13th March 2017) recommending that DoLS should be repealed and a new scheme introduced which was titled in draft: 'Liberty Protection Safeguards'. Proposed changes include an authorisation under the new scheme being applicable to any setting (including people living at home or in supported living accommodation) and an intention to clearly describe the differences between the use of the MHA (2007) or the new scheme. The proposed changes include wider adaptations to the MCA (2005) including a more stringent requirement to ensure that the wishes and preferences of the person are seen as of significant importance when making best interest decisions.

1.2.4 The wider mental health and restrictive interventions perspective

There is a body of wider mental health literature in relation to restrictive interventions for people with mental illness. There are some similarities with the dementia literature in that restriction is only recommended as a last resort as part of any care and treatment plan and the descriptors of types of restrictive interventions are heterogeneous across countries, particularly in relation to physical and mechanical restriction. In the wider mental health arena, notably in the literature and practice guidance, legislative discussion places an emphasis on the Mental Health Act (2007), the MHA Code of Practice (2015) and the overarching principles of the European Human Rights Act (1950). There is less emphasis on the Mental Capacity Act (2005) or the Deprivation of Liberty Safeguards (2009). The use of restrictive interventions in relation to wider mental health is driven by the same priorities as in dementia care settings – they should be used for the shortest possible time and to meet an

immediate need. There is also a focus on the avoidance of prone restraint as this approach represents a significant risk to service user safety. This focus is seen as paramount in the context of several incidents of service user injuries and deaths following physical restraint in adult mental health hospital settings (Cusack et al. 2016).

Additionally, the mental health restriction literature discusses a balance which service providers and mental health professionals are expected to achieve between assuring the safety of the public and staff while safeguarding the vulnerability of mental health service users. This is recognised as very challenging in contemporary mental health environments where resources are limited and the legal frameworks are complex. Public concern has grown following well publicised incidents of abuse linked to restrictive practice and service user led initiatives have championed further challenge of traditional restrictive or custodial approaches (Cusack et al. 2016). The Care Quality Commission requires providers of mental health services to provide training for staff in relation to any restriction and particularly for any and all physical interventions. The aim of all restrictive intervention training should be to avoid conflict and restriction by using person-centred care approaches.

The literature also discusses the psychological impact of restrictive practice for both service users and staff. The trauma suffered by service users can be both physical and psychological and can adversely impact on therapeutic relationships and recovery. Staff can also be psychologically affected as they struggle with role tensions. They need to maintain stability of care environments to ensure safety, while enabling autonomy and building relationships with service users. These

different requirements have the potential to introduce role conflict in terms of being both a carer and a custodian (Cusak et al. 2016; Riahi et al. 2016).

1.3 The Practice Challenges

There is broad recognition of the need for restrictive intervention practice across a range of mental health settings, including those which offer care and treatment to people with dementia – to protect both service users and staff. The complexity of the law and policy guidance is acknowledged as challenging for those in direct practice as mental health workers are required to act safely, understand the law and act in the least restrictive way at all times. Mental health workers across healthcare roles acquire knowledge in different ways dependent on the learning opportunities available to them and the types of knowing that they most readily engage with (Zander, 2007). The concept of knowing is not simple. When examined it is a complicated notion, particularly when applied to a complex area of healthcare such as restrictive practice (Benner, 1984; Carper, 1978; Jasper, 2003). It is acknowledged that while there is a will (MCA, 2005: DoH, 2014; DoLs, 2007) and an agenda (by regulatory bodies such as the Care Quality Commission) to reduce the use of restrictive interventions across health and social care settings, there are currently few alternatives to protect both service users and staff. The dynamics which influence restrictive practice are intricate and difficult to define and articulate for those in clinical environments but clarity and knowledge is needed to enable safe care and to reduce levels of restriction (Cusak et al. 2016; Jacob et al. 2016).

1.4 Research Setting

The research took place in two English counties where the local dementia demographic context suggested that by 2025 there would be 12,000 and 3000 people

with dementia respectively (Royal College of Psychiatry, 2016). Specifically, the research was set in two acute NHS mental health in-patient facilities for older people, provided by one mental health NHS Foundation Trust. Mental Health Trusts are required to establish robust training programmes and approaches for restrictive intervention practice (Dept of Health, 2014). The Executive Team and clinical leadership are responsible for the choice and application of restrictive approaches which are subject to regular scrutiny by the Care Quality Commission (DoH, 2014).

The two sites provided by the Trust differed in terms of environment and restrictive intervention approaches (Appendix 1). Site one employed Positive Behaviour Management as a restrictive intervention framework (PBM – this was a restrictive intervention training programme developed particularly for vulnerable service user groups). Site two employed Positive Management of Violence and Aggression (PMVA – this was a restrictive intervention training programme developed primarily for adult mental health settings). The rationale for hosting two different approaches across one Trust related to practical staff number considerations. Site one consisted of three wards, all delivering care and treatment to a vulnerable older age group and they were therefore able to coordinate restraint teams delivering solely PBM approaches. Site two also consisted of three wards but the patients comprised both vulnerable older adults and working age adults. The Trust concluded that this mixed hospital site must adopt a PMVA approach as PBM was judged as not meeting the physical challenges of restraint with younger adults.

One unit provided 16 beds in single room accommodation for people with dementia, where staff were trained to use restrictive intervention approaches tailored to vulnerable people (older people, people with dementia, people with a learning disability). The second unit provided ten beds for people with dementia, eight of which were in four bedded single sex shared dormitories. The staff in this unit were

trained to use restrictive intervention approaches tailored to adults with mental health issues.

Each year all English NHS Trusts which are providers of secondary mental health services are invited to participate in an NHS Mental Health Benchmarking exercise. This enables individual organisations to compare trends and benchmark themselves against the national data.

The benchmarking process shows a significant reduction in the number of mental health beds for older people in England since 2012 (which include beds for people with dementia). In 2012 there were 62 beds per 100,000 older people and in 2016 this had reduced to 27. Bed availability has decreased during this period but the impact for people with dementia and their families has been mitigated by the development of community services, supporting people to stay at home. Incidents of physical restriction are also captured in relation to 100,000 bed days. The host Trust report describes that it is not considered to be an outlier in terms of bed numbers, length of stay or physical restriction incidents in relation to this benchmarking exercise but specific figures are not accessible (NICE, 2005; 2gether NHSFT, 2017).

1.5 The Structure of the Thesis

The aim of this study was to understand the factors which shape restrictive intervention management by mental health care workers in an acute mental health setting for people with dementia. This first chapter provides an introduction and background to the research and sets out the dementia demographics for the UK. The chapter also considers the wider mental health perspectives on restrictive interventions and begins to describe the challenges faced by frontline staff.

Chapter two is the literature review which aims to systematically present and discuss the literature in relation to restrictive intervention practice for people with dementia. Literature published between 2006 and 2017 was reviewed and five themes were developed. The review concluded that there is a gap in the restrictive intervention and dementia literature particularly in relation to the experiences of staff.

Chapter three presents the methodology and research methods overview which outlines the epistemological approach and theoretical framework which structured the research. Interpretive description was used as a qualitative methodology to frame the research design which included intersectionality as an explanatory approach. The research included the use of semi structured interviews and vignettes. A thematic analysis, informed by the Braun and Clarke's (2006) six phase framework is outlined.

Chapter four provides an overview of the study findings. The key themes are identified (legislation as a maze, the organisational context, training and supervision and person-centred restrictive intervention practice) and explored in the context of how knowledge is translated into practice. Frontline staff were found to frame their restrictive intervention practice in a person-centred way, relying on practice leaders to understand and translate the broader context of law, research and literature.

Chapter five discusses the findings in the context of an extended epistemology to explain 'how we know' (Heron & Reason, 2008) and introduces the model of 'Translated Ways of Knowing' which I developed to critically review and understand the findings of the study. The chapter describes how mental health workers and practice leaders have distinct roles in translating knowledge to inform restrictive intervention practice for people with dementia. Limitations and study choices are also discussed.

Chapter six summarises and concludes the study by considering the study's implications for practice and contributions to knowledge. Finally, eight key recommendations are made: three for practice and five for further research.

Chapter Two: Literature Review

2.1 Introduction

The previous chapter defined key concepts in relation to restrictive interventions for people with dementia and highlighted the complexity which surrounds practice. This chapter systematically presents and critically discusses the literature to understand what is known about restrictive interventions and dementia practice. The findings are structured as a themed discussion which informs this research study.

Restrictive interventions are commonly used in care settings for people with dementia in many different countries. This literature review is characterised as a 'systematised review' and thematic synthesis (Grant & Booth, 2009). The review includes a comprehensive search, a critical appraisal of studies, and a synthesis and tabular report which describes what is currently known and what are the limitations of findings to date. The review describes the literature across the research paradigms enabling the identification of gaps and the need for further primary research. The review included studies based on both UK and international research to ensure sufficient material for a robust review but acknowledged the different legal contexts of different health systems. The method undertaken to review the literature was informed by Aveyard (2010) and Kable et al (2012) who broadly agree a systematic and stepped approach from framing the question to the synthesis of findings.

The literature review question was framed as:

What is the nature of restrictive intervention management by health care workers for people with dementia?

2.2 The Search Strategy

A detailed literature search was undertaken in 2015 prior to the commencement of any data collection for this study and updated in 2017. The second search elicited a relatively large number of results over a shorter time frame which is reflective of the growing interest in restrictive practice and legal frameworks in recent years (Valuing Every Voice, Respecting Every Right, 2014).

Search terms were informed by identifying and refining PICO elements (population, intervention, comparators, outcomes):

- P: Participants = health care workers or people with dementia in care environments: to include all professional groups and non-registered care staff.
- I: Interventions = restrictive interventions or restraint (mechanical, physical, chemical).
- C: Comparators = care settings (hospital, care home), differences in restrictive intervention approaches.
- O: Outcomes = impacts on staff or people with dementia.

The search was relatively broad to reflect the components of the review question: dementia, restraint, care staff and people with dementia. The search terms were identified following consultation with a specialist librarian from the host Trust - the term restraint was used rather than restriction as the latter did not yield any relevant results. Dementia was used as a MeSH Term (PubMed / Medline) but this produced large numbers of hits but no studies were identified as they related to medicalised research relating to various forms of dementia. Table 2.1 outlines the search terms used and more detail is provided in Appendices 3, 4 and 5. The search process was significantly enhanced by hand searching or 'back chaining', reviewing the reference lists of included studies to identify research which is relevant but not identified via

database searching, ensuring that seminal evidence or 'pearl citations' were not missed (Holloway & Wheeler, 2010; Kable et al, 2012).

Table 2.1 Search strategy – databases and terms

Search Strategy	Search Terms
General databases: Web of Science; Academic Search Complete	dementia AND restraint, dementia AND physical restraint, dementia AND staff AND restraint, dementia AND staff AND physical restraint
Specific (Health) databases: Medline, Cinahl, Psychinfo; Cochrane; PubMed.	dementia AND restraint, dementia AND physical restraint, dementia AND staff AND restraint, dementia AND staff AND physical restraint

Lancaster University library 'One Search' facility was utilised as a secondary search and grey literature source and a general internet search was undertaken– in practice these additional sources were of limited use as they yielded a large number of unrelated results (search strategy result tables are included as Appendices 4 and 5). Table 2.2 describes the inclusion and exclusion criteria which were applied. The criteria for the review enabled studies with any and all forms of restriction to be included.

Table 2.2: Inclusion and Exclusion criteria

Inclusion Criteria	Exclusion Criteria
English language papers	Non-English language papers
Studies published after 2006	Published before 2006
Qualitative and quantitative and mixed methods studies	People with dementia living at home
Dementia care settings (care home, hospital)	Non-dementia care settings
Health care workers or people with dementia in care environments	Home care studies
Restrictive interventions (mechanical, physical, chemical)	

The time frame of the search strategy was linked to changes in mental health legislation, notably the introduction of the Mental Capacity Act (2005) which significantly impacted on dementia care practice when it came into force in 2007. The exclusion of non – English papers was applied for pragmatic language reasons but it is acknowledged that some international studies may have been missed (Duxbury et al, 2013).

2.3   Data Extraction

Data extraction was structured by an Excel based literature review tool which was informed by the University of York guidance for undertaking reviews in health care (University of York, 2009) and also by Dixon-Woods et al (2006). It was also influenced by the comprehensive data extraction format utilised by NICE (2007) which uses an approach to enable the assessment and synthesis of research evidence resulting from diverse methodological approaches. The process of data extraction facilitated the tabulation of data and also began the process of data synthesis.

2.3.1 Methodological Quality Assessment

An Excel tool was constructed to assess the methodological quality of the studies selected for the literature review (qualitative, quantitative and mixed methods). This tool was influenced by the Critical Appraisal Skills Programme (CASP) Research Checklist (2013) and Cardiff University's Support Unit for Research Evidence - Questions to assist with the critical appraisal of qualitative studies (2012). Qualitative studies were assessed in relation the appropriateness of the research question to the chosen method, sampling approach and size, and evidence of rigorous data collection and analysis (Aveyard, 2010). Quantitative studies were assessed in terms of evidence of a research question appropriate to numerical measurement, appropriate sample sizes and response rates. Evidence of statistical analysis and risk of bias were also assessed, particularly in relation to the randomised controlled trials (RCT's) which were included in the review (Aveyard, 2010; Higgins & Green, 2011). This approach was informed by the critical appraisal guidance in Aveyard (2010) which offered a broad framework which captured a number of methodological approaches. The Excel tool enabled the early identification of themes - within individual studies and across diverse approaches, as concepts emerged.

2.4 Review Findings: Synthesis

The included studies were undertaken by researchers from different backgrounds (psychology, medicine, physiotherapy, nursing and social work) and the papers were published in a variety of professional and academic journals, most with an international circulation. Appendices 4 and 5 detail the numbers of papers identified and eliminated at different stages of the review.

Tables 2.3 and 2.4 detail the main characteristics of each study. In summary, five studies were UK based, 17 were non-UK. Four of the studies were randomised controlled studies (RCTs) (one in the UK), 18 studies were quantitative in nature –

non RCTs (three in the UK), three studies used mixed methods and two studies were qualitative by design (both in the UK). As data was extracted and entered into the Excel tool – it allowed for similarities and differences to be noted in terms methods and findings (Aveyard, 2010).   Five themes related to the search strategy were developed as related findings were linked:

1. Staff education and restriction levels.

2. Staff supervision (consultancy, guidance, coaching) and restriction levels.

3. Dementia as a predictor of restriction

4. Alternatives to restriction

5. Gender, dementia and restriction.

 These themes were explored in the context of a systematised review which enabled an analysis of the quality of findings (Grant and Booth, 2009). The term service user will be used throughout the review as an umbrella term for residents or patients. Additionally, the term restriction rather than restraint will be used wherever possible (unless the term restraint has been expressly used by an author or participant). Tables are used to present and understand the methods and findings of the studies included in the review. Tabulated results and narrative description acknowledge study sizes and methodological quality to suggest whether findings are credible or significant.

Definitions of restriction are heterogeneous across studies, particularly physical and mechanical restriction descriptors. These differences are not surprising given the legal and policy frameworks of countries other than the UK.   There were wide variations in terms of law, legislation, policy and practice (Mohler et al. 2012; De Bellis et al. 2011). Most Western developed countries however did adhere to international guidance (the European Convention on Human Rights 1950; World

Health Organisation, 2007), and some had detailed legislation. In European Union countries (12 of the studies) the governments are committed to a framework for mental health which focuses on personal freedoms, mental well-being and a commitment to minimise restriction associated with mental health and illness (European Framework for Action on Mental Health and Wellbing, 2016). This approach also holds true for Scandinavian countries where mental health services have been modernised and prioritised (Diseth and Hoglend, 2014; Silfverhielm & Kamis-Gould, 2000). Tables 2.3 and 2.4 detail types of restriction as described by individual studies and then clarify how this type of restriction would be defined in the UK (Positive and Proactive Care, 2014). In relation to study settings, 11 studies were set in care homes (Brandi et al. 2014; Duxbury et al. 2013; Fossey et al. 2006; Freeman et al. 2017; Huizing et al. 2006; Mcdonald, 2007; Pulsford et al. 2011; Testad et al. 2010; Verbeek et al. 2014; Willemse et al. 2016; Zwijsen et al. 2011). A further eight studies were set in non-mental health hospital environments (Ang et al. 2015; Milke et al. 2008; Nakahira et al. 2008; Natan et al. 2010; Pellfolk et al. 2012; White et al. 2017; Yamamoto & Aso, 2009; Yan et al. 2009), with three set in mental health environments (Gerace et al. 2013; Haude et al, 2009; Pellfolk et al. 2010) Table 2.3 details the main study characteristics of the two qualitative studies included in the review and Table 2.4 provides detail for the quantitative and mixed methods studies.

Table 2.3: Study characteristics (qualitative studies included in the review)

	Reference	Strategy Design Methods Intervention Follow up	Research Question and Objective	Sample number and type	Participant Demo- graphics if reported	Setting	Type of restriction	Outcomes
1.	Duxbury et al 2013 (UK)	Interviews Focus groups No intervention No follow up	To understand the reasons for and ways to respond to aggression	8 staff	Gender: 75% women	Care Homes	Not defined	Not clear
2.	Macdonald 2007 (UK)	Interviews No intervention No follow up	To explore the views and experiences of care assistants	10 staff	Gender and Ethnicity and Age: Not Known	Care Homes	Not defined	Care assistants seek clear, practical leadership plus information

Table 2.4: Study Characteristics (Quantitative and Mixed Methods studies included in the review)

	Reference	Strategy Design Methods Intervention Follow up	Research Question and Objective	Sample number and type	Participant Demo-graphics if reported	Setting	Type of restriction	Outcomes
1.	Ang et al. 2015 Singapore	Prospective observational study No intervention Daily follow up until discharge	Prevalence, complications and associated service user characteristics of physical restraint in an acute care setting.	998 service users	65 yrs + 56 % Women	Acute care hospital	Physical (UK definition - mechanical)	Characteristics that predict restraint: Male and Memory disturbance Behavioural changes and↓ physical functioning. Use of antipsychotic drugs ↑workload for staff
2.	Brandi et al 2014 (Europe and Israel)	Analysis of case record data No intervention No follow up	To describe the use of antipsychotic drug & physical restraint use - and their impact on one year mortality	2278 Service Users	Gender : 74% women Ethnicity Age	Nursing homes	Physical (UK definition - mechanical)& Chemical	Physical restraint increases risk of death
3.	Fossey et al 2006 (UK)	Cluster RCT Questionnaires and assessments Intervention: Educational intervention (staff training and support over 10 months) 12 months Follow up	To evaluate the effectiveness of a training and support intervention for nursing home staff in reducing the proportion of residents with dementia who are prescribed neuroleptics	349 Service Users	Gender: 37% women	Nursing Homes	Chemical	19% reduction in prescription of neuroleptics (in the intervention group)

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4.	Freeman et al. 2017 (Canada)	Analysis of secondary data Longitudinal study No intervention 3month follow up	Physical restraint and the use of antipsychotic drugs and social engagement to change cognitive status in residents newly admitted to long term care	111,052 residents	68.9% Women 94.6% 65 yr +	Care Homes	Physical (UK definition - mechanical) and Chemical	Physical restraint is a risk factor for cognitive decline. Social engagement is a protective factor. Antipsychotic drugs are not a significant factor in cognitive decline.
5.	Gerace et al 2013 (Australia)	Analysis of restraint incidents in case records No intervention Longitudinal study	To provide an analysis of restraint incidents in one hospital campus in Australia	495 Service Users	Gender: 61% women	5 wards on a hospital campus	Physical (UK definition - mechanical)	Dementia is a predictor of restraint. Restraint is more likely early in an admission
6.	Haude et al 2009 (Germany)	Mixed methods: Data extraction of case records Qualitative description of incidents No intervention	To investigate service users with dementia in 2 German hospitals prospectively investigate treatment variables compared	113 Service Users	Gender: 45% women	Specialist dementia unit versus traditional psychiatric unit	Chemical	Specialist units + increased length of stay and increased levels of restraint Reduced levels of psychotropic medication and reduced discharges to institutions
7.	Huizing et al 2006 (Netherlands)	RCT observation study Intervention: Education programme and consultation with specialist nurse No follow up	To investigate the short term effects of an educational intervention on physical restraint use via a cluster randomised trial	167 Service Users	Gender: 90.7% women	Nursing home 'wards'	Physical(UK definition - mechanical)	No significant change in intervention group. Restraint increased in control group

8.	Milke et al 2008 (Canada)	Review of incident data over 4 years Intervention: Restraint reduction programme of education No follow up	To evidence mechanical restraint levels	1200 Service Users	N/A	Continuing care units	(UK definition - mechanical)	In house champions and small units equal restraint reduction
9.	Nakahira et al 2008 (Japan)	Cross sectional surveys No intervention No follow up	To investigate attitudes & explore the relationship between staff attitudes, professional characteristics & practice	675 staff	Gender: 77.9% women	Aged care settings in Japan	Physical (UK definition - mechanical)& Chemical	Education must include understanding of behaviour and dementia (ie restraint training only does not reduce levels of restraint)
10.	Natan et al 2010 (Israel)	Questionnaire to staff No intervention No follow up	To identify & analyse the major variables affecting intended decisions of nursing staff to physically restrain residents	104 staff	Gender: 90.4% women	Long term care facilities	Physical (UK definition - mechanical)	Dementia is a predictor of restraint.
11.	Pellfolk et al 2012 (Sweden)	Cross sectional surveys No intervention No follow up	Not stated	In year 2000: 4214 service users	Gender: 67.7% women	Geriatric units some specific to people with dementia	Physical (UK definition - mechanical)	Not clear
				In year 2007: 3532 service users	Gender: 68.1% women			

12.	Pellfolk et al 2010 (Sweden)	Cluster RCT Questionnaires Intervention: 6 month education programme for nurses and aides 12 month follow up	To evaluate the effects of a restraint minimisation programme on staff knowledge and attitudes and use of physical restraint	At Follow Up 350 service users 289 staff	Gender: 76% women (staff) % women (residents)	Group dwellings for people with dementia	Physical (UK definition - mechanical)	Dementia is a predictor of restraint. Education = restraint reduction. Falls and levels of psychotropics not effected
13.	Pulsford et al 2011 (UK)	Survey of staff Audit of incidents Intervention: staff survey No follow up	To explore paradigms of understanding of dementia	36 staff	Gender: 72% Women	Nursing Homes	Not defined	Aggression is situation driven (a person-centred belief)
14.	Testad et al 2010 (Norway)	RCT Audit of incidents Questionnaires to staff Intervention: Education and guidance to staff 12 month follow up	To evidence whether education & supervision reduce restraint and drug use for people with dementia	145 service users	Gender: 74% women	Nursing homes	Physical (UK definition - mechanical)	Training and support reduces levels of restraint. No change in prescribed drug use and the effects of supervision 'wear off'
15.	Verbeek et al 2014 (Netherlands)	Questionnaire to staff about residents 6 & 12 month follow up	To test a model used to promote resident directed care	259 service users	Gender: 75% women	Small scale care homes plus traditional psychiatric ward	Physical (UK definition - mechanical)	Small scale care settings equal reduction in restraint and medication use

16.	White et al. 2017 UK	Questionnaire Longitudinal study No intervention Follow up every 4 days until discharge	To investigate how behavioural and psychological symptoms of dementia are managed in UK medical hospitals	230 service users	70 yrs + 65.7% Women 76.1% white British	Acute general medical hospital	Physical (UK definition - mechanical)	40% were prescribed medication 55% received non-pharmacological interventions. 22% received restraint. Pts who were prescribed antipsychotic medication were significantly more likely to die.
17.	Willemse et al. 2016 (Netherlands)	Survey No intervention No follow up	To investigate if an unhealthy work environment in facilities for people with dementia are associated with more psychotropic drugs and physical restraints.	996 staff 1,138 residents	Staff 32-55 yrs 94% Women Residents 71-89 yrs 76% Women	Nursing homes	Physical and (UK definition mechanical) and chemical	Increased supervision is linked to reduced prescribing of psychotropic drugs, No significant relationship found between job demands and levels of physical restraint.
18.	Yamamoto & Aso 2009 (Japan)	Questionnaire No follow up	To clarify coping strategies of nurses in wards restraining people with dementia	272 staff	Gender and Ethnicity andAge: Not Known	Community Hospitals (including people with dementia)	Physical(UK definition - mechanical)	Ethical education improves restraint judgement
19.	Yan et al 2009 (Hong Kong)	Questionnaire No intervention No follow up	To examine the prevalence and correlates of the use of restraint and force in care for older people in the hospital setting in Hong Kong	187 staff	Gender: 86.6% women	Medical wards (including people with dementia)	Physical (UK definition - mechanical)& chemical	Emotional well-being of staff is predictive of restraint reduction

20.	Zwijsen et al 2011 (Netherlands)	Mixed methods: Interviews Focus groups Questionnaires No intervention No follow up	To explore how care professionals and family members of nursing home residents with dementia in the Netherlands experience & define the concept of restraint	271 staff 16 relatives	Gender and Ethnicity and Age: Not Known	Nursing Homes	Physical (UK definition - mechanical)	Need to understand the intent of the restraint (local logic)

2.4.1 Methodological summary

The tables and text below describe a number of methodological issues – some studies were at risk of recruitment or selection bias, while others had small numbers in relation to the study design. Comparison between studies was also complicated by the variety of settings. Although each setting related to people with dementia in a care setting, they varied considerably in terms of sample size and country of origin (Tables 2.3 and 2.4). All of the studies except Brandi et al. (2014) acknowledged limitations – these are detailed in Tables 2.5 – 2.8.

2.4.2 Quality assessment: methodological issues

Studies were grouped in relation to design to assess their methodological quality and credibility. A described earlier, the randomised controlled trials (RCT's) included in the review were assessed in terms of methodological quality and risk of bias to enable a weighted credence of findings (Higgins & Green, 2011).

Table 2.5: Ranking of RCT studies.

	Selection bias (1) (generation via random sequence)	Selection bias (2) (concealment of allocation)	Selection bias (3) No group baseline inequity)	Recruitment bias (Identification of participants before randomisation)	Attrition bias (No clusters lost to follow up)
Fossey et al. (2006)	**NO**	**YES**	**YES**	**Yes**	**YES**
Huizing et al. (2006)	**Yes**	**YES**	**NO**	**Not Clear**	**YES**
Pellfolk et al. (2010)	**YES**	**NO**	**Not Clear**	**Not clear**	**YES**
Testad et al. (2010)	**Not clear**	**Not Clear**	**No**	**Not Clear**	**YES**

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Following the review of bias detailed in Table 2.5 above, the RCT studies can be ranked in order of methodological credibility, suggesting Fossey et al. (2006) as the most credible study.

2.4.3 Quantitative studies (excluding RCTs)

Brandi et al. (2014) was included in the review as it met the review inclusion criteria. The methodology section however was not sufficiently detailed to enable inclusion in Themes 1-4. Table 2.6 below outlines some of the methodological issues with the quantitative studies included in this review.

Table 2.6: Methodological issues with the quantitative studies (excluding RCTs).

Study	Design	Methodological issues
Ang et al. 2015	Prospective observational study	Inter-rater reliability issues – raters of workload were different nurses, from different wards with different levels of experience. Some data was missing about service user variables – the interpretation may therefore be misleading. Nurse attitudes towards restriction were not known.
Freeman et al. 2017	Analysis of secondary data Longitudinal study	The data collection tool did not allow for appropriate restriction to be recorded. The tool collects drug use within a timed window – this may have resulted in under reporting.
Gerace et al. 2013	Analysis of restraint incidents in case records	The study had no access to Antecedent and Behaviour and Consequence (ABC) data (so no context to the incidents). The study is based on self reports of participants – under reporting is a risk. .
Milke et al. 2008	Review of incident data over 4 years	The sample size (n=1200) is appropriate for the type of study The study is based on mental health worker reports of incidents: under reporting is a risk.

Nakahira et al. 2008	Cross sectional surveys	The views of non-responders are not known – sample bias is a risk. There is no observation element to test the self reporting.
Natan et al. 2010	Questionnaires	The sample size (n=104) is low for the type of study. The study is based on self reports of participants – under reporting is a risk. The study focuses on a single care facility – sample bias is a risk
Pellfolk et al. 2012	Survey	Large sample (n= 3532) All data is reported by mental health workers looking back over 7 days (none is observed). Potential for recall bias.
Pulsford et al. 2010	Survey	The sample size (n=36) is very low for the type of study. Detailed data analysis was not possible. The study focuses on a single care provider –sample bias is a risk
Verbeek et al. 2014	Questionnaire to staff about residents	Adequate sample for study design (n=259) No random assignment of participants – risk of bias to sample and results (difficult to assign causing effect to findings).
Yamamoto et al. 2009	Questionnaire	Small sample (n=272) Staff characteristics are not examined and the questionnaire is at a single point in time so no ability to observe change
Yan et al. 2009	Questionnaire	Small sample for this design (n=187). Self reported data (no observation or verification of restriction used). The study had no access to Antecedent and Behaviour and Consequence (ABC) data (there is no context to the incidents as the study is cross sectional in design).
White et al. 2017	Questionnaire Longitudinal study	Potential reporting bias (less severe symptoms may not have been reported). Reasons for prescribing medication not collected – may have been valid and not restrictive. Non-pharmacological interventions only captured if recorded – possible under recording. Data was taken from larger study – possible distortion and bias
Willemse et al. 2016	Survey	Care homes with low survey response levels were excluded (low response may have been indicative of high levels of job demand. Staff and residents were randomly selected – selected staff may not have been providing care for selected residents

2.4.4 Mixed methods studies

Table 2.7 below outlines some of the methodological issues with the mixed methods studies included in this review.

Table 2.7: Methodological issues with the mixed methods studies

Study	Design	Methodological issues
Haude et al. 2009	Data extraction of case records of 50 service users with dementia. Comparison undertaken between demographic data, medication and diagnosis Qualitative description of incidents by care givers	Mixed methods but little emphasis on qualitative element (descriptions of aggressive behaviour by care givers) Refers to a follow-up study planned to understand longitudinal issues (unable to locate)
Zwisjen et al. 2011	Interviews with relatives and nursing home staff Focus groups with nursing home staff Questionnaires to nursing home nurses	Surveillance technology is a key feature of the study but not referred to in the title (this impacts on literature searching) The qualitative data 'tested' quantitative findings revealing some contradictions

2.4.5 Qualitative studies

Table 2.8 below outlines some of the methodological issues with the qualitative studies included in this review.

Table 2.8: Methodological issues with the qualitative studies.

Study	Design	Methodological issues
Duxbury et al. 2013	Semi structured interviews with care home staff (n=8) Focus groups with relatives (n=6) and (n=2)	Care homes based study- all same provider (potential for sample bias and not representative of wider care home provision). Focus groups; one group contained only 2 participants (no rationale given)
MacDonald et al. 2007	Semi structured interviews with care assistants (n=10)	Interviews with care assistants Detail of data analysis very limited Small sample acknowledge and does not seek to offer significant conclusions

2.5 Thematic Synthesis

The literature was limited in terms of quantity and relevance to my research. Of the 22 studies considered, only two were qualitative (Duxbury et al. 2013; Mcdonald, 2007), five were set in the UK (Duxbury et al 2013; Fossey et al 2006; Macdonald, 2007; Pulsford et al 2011; White et al. 2017) and just three in mental health environments (Gerace et al. 2013; Haude et al, 2009; Pellfolk et al. 2010). The review of the literature to identify themes was further complicated by restraint legislation which differed across countries, and the basis of which was not always known. The included studies did not engage directly with people with dementia and relied largely on self-reports from staff. The strengths and limitations of the literature will be explored further as the themes are described.

An excel based quality extraction and assessment tool was developed which facilitated the identification of comparable findings and differences in methods (Aveyard, 2010). The tool provided a structure for questions which assisted the critical appraisal of the literature. Themes were developed by comparing and contrasting findings in the context of methodological quality, themes were linked and some literature gaps identified. A page of the excel tool detailing the data extraction element is included as Appendix 2.

Five themes related to the search strategy were developed as related findings were linked:

1. Staff education and restriction levels.
2. Staff supervision (consultancy, guidance, coaching) and restriction levels.
3. Dementia as a predictor of restriction.
4. Alternatives to restriction.
5. Gender, dementia and restriction (the absence of attention to gender).

Themes one and two were overtly identified by individual studies via the research questions and objectives (Fossey et al. 2006; Huizing et al. 2006; MacDonald et al. 2007; Milke et al. 2008; Nakahira et al. 2008; Pellfolk et al. 2010; Testad et al. 2010; Verbeek et al. 2014; Yamamoto & Aso 2009; Yan et al. 2009; Zwijsen et al. 2011). Theme Three was not overtly identified by individual studies at the outset of their research but dementia was identified as a predictor of restriction in the findings of four studies (Gerace et al. 2013; Natan et al. 2010; Pellfolk et al. 2010; Ang et al. 2015). Theme four relates to two studies which identified non-restrictive approaches as alternatives to restriction (Freeman, 2017; White, 2017).

Theme five was identified from observing the lack of attention to gender across most studies. In relation to this review of literature, 21 studies described gender as a

characteristic of participants but did not comment further while one study offered further exploration (Gerace et al. 2013).

2.5.1 Theme one: Staff education and restriction levels.

Seven quantitative studies set out to explore or examine the impact of staff education and training on restriction levels. Table 2.9 details the studies which relate to this theme.

Table 2.9: Results of studies which examined the effect of staff education and training on restriction levels

Study	Design	Type of restriction	Impact on restriction levels
Huizing et al. 2006	Observation study	Physical	⇔ (no change)
Milke et al. 2008	Review of incident data over four years	Mechanical	⇩(reduced)
Nakahira et al. 2008	Cross sectional survey	Mechanical & Physical	⇩(reduced)
Pellfolk et al. 2010	Cluster RCT	Physical	⇩(reduced)
Testad et al. 2010	Audit of incidents Questionnaires	Mechanical & Physical	⇩(reduced)
Yamamoto & Aso 2009	Questionnaires	Physical	Not stated
Yan et al. 2009	Questionnaires	Not defined	Not stated

The methodological quality and associated issues of all included studies were discussed more fully earlier in this Chapter. Pellfolk et al (2010) and Testad et al (2010) had issues in relation to selection and recruitment bias. Huizing et al (2006) detailed the methodology with greater clarity and had fewer issues in relation to bias. It may be argued therefore that the Huizing et al (2006) findings were more credible (Aveyard, 2010).

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From Table 2.10, four of the studies were able to evidence a reduction in restriction following an intervention to staff of education and training. Huizing et al (2006) did not evidence any reduction in restriction in the short term (the duration of the study). Nakahira et al (2008) and Milke et al (2008) both relied on self-reported practice – this is noted as a limitation in that the views of non-responders were not known and findings are therefore weakened. The longer-term impact of staff education on restriction levels was not known for some studies (Huizing et al. 2006; Pellfolk et al. (2010). Testad et al. (2010) did follow up at 12 months – the impact of reduced levels of mechanical and physical restriction was not sustained at 12 months. Milke et al. (2008) conducted their study over a longer, four year period – so were able to evidence some longitudinal sustainability in terms of mechanical restriction reduction.

Milke et al. (2008) and Pellfolk et al. (2010) both demonstrated reduced levels of restriction where the care setting was small. Milke et al. (2008) included a variety of settings in terms of size and noted significant reductions in smaller units whereas the Pellfolk et al. (2010) study was set *only* in small units. Pellfolk et al. (2010) suggested that small units for people with dementia were able to offer higher staffing levels which facilitated person-centred practice approaches, reducing the need for restriction. Yamamoto & Aso (2009) did not measure the impact of training on levels of restriction but found that nurses believed that educational support enabled restriction decisions – potentially impacting positively on restriction reduction. In contrast, Yan et al. (2009) found that training in dementia care was not related to restriction levels. They concluded that social support, policy and practice guidance were required to reduce restriction incidents.

In summary, the review suggested that staff education and training approaches of varying types (detailed in tables 2 and 3) positively impacted on restriction reduction, but further research is warranted to test the credibility of findings and to understand the longer-term effects and sustainability. This agrees with the findings of Bird et al. (2016) who undertook a systematic review to examine whether interventions with care staff positively impact on people with dementia. They concluded that research often ends too early to understand whether evidenced improvements are sustained.

2.5.2 Theme 2: Staff supervision (consultancy, guidance, coaching) and restriction levels.

Seven studies examined or explored staff support and the use of restrictions with people with dementia. Support was described differently by various authors (see Table 2.10) – the umbrella term of supervision is used for this thematic discussion. Supervision is used across all mental health disciplines and generally involves the meeting of mental health workers to discuss clinical and professional issues in a structured format (Hawkins & Shohet, 2012).

Table 2.10: Results of studies which examined the impact of staff support on restriction levels

Study	Study design	Type of restriction	Type and description of supervision	Impact on restriction levels
Fossey et al. 2006	Questionnaires	Chemical	Group and case supervision	⇓(reduced)
Huizing et al. 2006	Observation	Physical	Consultation with specialist nurse	⇔(unchanged)
MacDonald et al. 2007	Semi structured interviews	Not defined	Practical guidance and information	Not stated
Milke et al. 2008	Review of incident data	Mechanical	Access to an onsite champion	⇓(reduced)

Testad et al. 2010	Audit of incidents Questionnaires	Physical & Mechanical	Group guidance sessions	⇩(reduced)
Verbeek et al. 2014	Questionnaires	Physical & Mechanical	Accessible peer support	Not stated
Zwijsen et al. 2011	Interviews Focus groups Quesionnaires	Physical & Mechanical	No intervention	Not stated

Three of the studies did not report findings of restriction level changes and one study reported no change. Zwijsen et al. (2011) found that it was important for the care and treatment team to understand the 'local logic' behind restriction use – for mental health workers to be able to articulate their thinking and intentions in relation to restriction. The provision of supervision facilitated this articulation. Verbeek et al. (2014) evidenced that their intervention of accessible peer support (in small care settings) reduced the levels of physical and mechanical restrictions.

Fossey et al. (2006) described in detail group and individual supervision over a 10-month period as part of their intervention. A 12 month follow up showed significant reduction in neuroleptic drug use (chemical restriction) in the 'intervention care homes'. Results also indicated that levels of agitated behaviour and aggressive episodes were not significantly increased over the same period.

MacDonald et al. (2007) described the importance of supervision in relation to practice. Care assistants in UK care homes were interviewed and described supervision in terms of practical support and guidance which care assistants needed in order to sustain person-centred care for challenging behaviour for people with dementia.

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Of the seven studies which included or referred to a supervisory intervention or theme (Table 2.10) – all suggested that supervision was important in terms of embedding learning and sustaining knowledge and skills which may reduce restriction use. As discussed earlier, the majority of studies within this review were non-UK and quantitative in nature. In relation to this theme, two of the studies were UK based and one was qualitative. These methodological and contextual differences made comparisons of supervision complex as the nuances of clinical practice and supervision requirements and expectations were not shared.

2.5.3 Theme three: Dementia as a predictor of restriction

Restriction use in mental health care and treatment was commonplace prior to the advent of psychotropic medication in the 1960's. Since that time, the use of restriction techniques has declined in relation to all mental health conditions but it does remain an issue for people with dementia. A 2004 review of restraint and restriction literature (Wang & Moyle, 2004) identified studies which continued to establish a link between cognitive impairment and restriction (Burton et al. 1992a, 1992b). In relation to this review of restriction literature, four studies identified dementia as a predictor of restriction (Ang et al. 2015; Gerace et al. 2013; Natan et al. 2010 & Pellfolk et al. 2010). (Table 2.12).

Table 2.11: Findings of studies which identify dementia as a predictor of restriction.

Study	Design	Type of restriction	Findings
Gerace et al. 2013	Analysis of incidents	Physical & Mechanical	People with dementia received more frequent restriction than people with mental health conditions
Natan et al. 2010	Questionnaire	Physical	Link between service user characteristics & restriction (dementia being a key characteristic)

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Pellfolk et al. 2010	Questionnaires	Physical	Possible link between levels of restriction and cognitive decline in people with dementia during an admission
Ang et al. 2015	Observation	Physical	The strongest service user characteristic associated with restriction was memory disturbance

Two studies (Haude et al. 2009 & Pulsford, 2011) identified service user characteristics but did not find a correlation between dementia or severity of dementia and restriction. Pellfolk et al. (2010) offered a tentative explanation of an increase in restriction use for people with dementia who were present throughout their study. They suggested that the progression of dementia, evident across the duration of their study (service users were followed up at six months) was a predictor of increased restriction use.

Natan et al. (2010) produced results which identified a significant association between the characteristics of a service user (dementia being a key characteristic) and the risk of being restricted during the process of care and treatment. It was suggested that this may be driven by a sense of protectiveness – an intention to prevent falls and self-harm, but cannot be clearly evidenced as such. Ang et al (2015) identified a number of service user characteristics associated with restriction use – memory disturbance was the most significant.

The Gerace et al. (2013) study was a retrospective analysis of incidents within a mental health service (providing care and treatment for people with dementia and other mental health conditions). Physical and mechanical restriction incidents were reviewed: service users with a dementia diagnosis were restricted more frequently than those with other mental health disorders. The study referred to a stress

threshold model which suggested that this finding may relate to dementia and the impact on people with dementia and their ability to manage stress:

Dementia = lowered stress threshold = behaviour that challenges = increased use of restriction (Smith et al. 2004).

This model may also explain why (in the Gerace et al. 2010 study) people with dementia were more likely to be restricted early in an admission when acute symptoms and confusion are likely to be more apparent. This is in contrast to the suggestion by Pellfolk et al (2010) that deterioration in cognitive function is a predictor of restriction. The findings of Gerace et al. (2010) are however more compelling than those from the other studies detailed in Table 2.11 as the study was able to directly compare people with dementia with other distinct service user diagnostic groups.

2.5.4 Theme 4: Alternatives to restriction

Two studies identified non-restrictive approaches to manage behavioural and psychological symptoms of dementia. Table 2.12 below details the studies which relate to this theme.

Table 2.12: Alternatives to restriction

Study	Design	Type of approach	Findings
White et al. 2017	Questionnaires	Psychosocial eg: Complementary therapies Life history Reminiscence	55% of participants received psychosocial interventions. Recording and monitoring of effectiveness was found to be poor
Freeman et al. 2017	Secondary data analysis	Social engagement – self initiated or organised. Individual or group (providing occupation and distraction)	Found to be a protective factor against cognitive decline and associated behavioural and psychological symptoms of dementia (which may be managed using restrictive interventions).

Both of these very recent studies contain methodological issues (Table 2.4) and they are attempting to research an area of practice which is poorly defined, recorded and evaluated (Bird, 2016). White et al (2017) specifically commented that they found little evidence of monitoring of the effectiveness of psychosocial interventions. Quantitative approaches therefore which rely on collection of recorded or reported data may not be the best vehicle to capture evidence relating to alternatives to restriction. Qualitative interviews and exploration may have elicited more detailed information.

2.5.5 Theme 5: Gender, dementia and restriction (the absence of attention to gender).

The number of women participants as descriptive demographic data was included in many of the studies – but it was rarely addressed as a specific focus. There are a number of literature review papers which provided a critical assessment of the literature in relation to restrictions and people with dementia (De Bellis et al, 2011; Mohler et al. 2012; Wang & Moyle, 2004) but again, the issue and implications of gender are not acknowledged or explored. Of the 22 studies reviewed here gender data was a demographic feature of 18 of them. Tables 2.13 and 2.14 below give further detail.

Table 2.13: Studies where samples are staff members – illustrating numbers and percentages of women

Study	Sample: Staff n=	Number of sample who are women	Percentage sample who are women
Duxbury et al. 2013	8	6	75%
Nakahara et al. 2008	675	525	78%
Natan et al. 2010	104	94	90%
Pellfolk et al. 2010	350	266	76%
Pulsford et al. 2011	36	26	72%
Yan et al. 2009	187	161	87%
Willemse et al. 2016	993	940	94.%
All studies within table	**2353**	**2018**	**85%**

Table 2.14: Studies where samples are service users – illustrating numbers and %'s of women

Study	Sample: Service User n=	Mean Number of sample who are women	Mean number as a % sample who are women
Brandi et al. 2014	2271	1680	74%
Fossey et al. 2006	349	129	37%
Gerace et al. 2013	495	301	61%
Haude et al. 2009	113	51	45%
Huizing et al. 2006	167	155	93%
Pellfolk et al. 2012	3532	2401	68%
Pellfolk et al. 2010	289	247	85%
Testad et al. 2010	145	107	74%
Willemse et al. 2016	1138	868	76%
Ang et al. 2015	998	559	56%
Freeman et al. 2017	111052	16502	69%
White et al. 2017	230	151	66%
Verbeek et al. 2014	259	194	75%
All studies within table	**121,038**	**83,345**	**68%**

The tables above detail that significantly more women were involved in the reviewed study samples than men. Macdonald et al. (2007), Milke et al. (2008), Yamamoto & Aso, (2009) and Zwijsen et al. (2011) did not contain gender information.

Table 2.13 illustrates that in relation to research with staff groups (seven studies), women comprised >70% of every sample. With service user research studies (Table 2.14), women comprised > 60% in 10 of the 13 studies. Despite the gender differential, only two of the studies offered any explanation or further analysis of gender.

Pellfolk et al. (2012) identified that 68% of their service user sample are women. They also found that being male is a risk factor for being physically restrained (other factors being cognitive impairment, limited self-care ability, mental health symptoms and taking antipsychotic medication). There was no further analysis in relation to gender. Gerace et al. (2013) is the only paper which discussed the relationship between dementia, restriction and gender. They acknowledged that in their study more men were restricted than women.

The study findings suggested that participant gender alone is not a reliable predictor of restriction and that other variables are worthy of consideration:

- The gender of any intended recipient of aggression (who is the person with dementia threatening when restriction is applied)
- Individual nurse perceptions of thresholds to aggression.

Despite the evidence base relating to gender differences, the studies of dementia and restriction did not appear to consider or explore the issues.

2.6 Discussion

The synthesis element of this review aims to provide a narrative which addresses the review question and understand the findings of the studies considered. The thematic structure seeks to connect results from individual studies to present shared findings (Gough et al. 2012). The complexity of the issues and the limited research available

means that the review question remains only partially answered. There was insufficient literature either within the UK or across a single research paradigm to facilitate a review which is focussed on a single system (eg: NHS) or within a single research approach (eg: qualitative). Therefore, although comparison across methodological approaches is challenging, it is well supported by the literature and adds breadth and depth to the review process (Gough et al. 2012). Most of the studies reviewed offered cross sectional designs (only White et al, 2017 and Freeman et al, 2017 include longitudinal data). Brief periods of research cannot offer a behavioural context to the initiation of restrictive interventions and there was therefore limited illustration of nuance. Physical and psychological triggers were largely unknown as were key characteristics (gender, age, experience) of staff or other service users involved in each episode of restriction. Additionally, the perspective of people with dementia was not directly sought by any study included in this review – this was acknowledged as a challenge by Zwisjen et al. (2011). The themed findings do however provide evidence that education and supervision are valued by staff and can reduce levels of restriction in the short term (Tables 2.10 and 2.11).

The review illustrated the issue of gender across multiple studies (Table 2.13 and Table 2.14). Alzheimer's Disease International (2015) in their report titled Women and Dementia suggested that men and women approach the task of caring differently, men as a pragmatic task based activity while women focussed on quality and emotion (Godfrey & Warshaw, 2009). Although the significance of gender is only acknowledged by one study (Gerace et al. 2013), supporting literature strengthened the suggestion that 'gender awareness' is beneficial. In relation to staff education and support it could enable person-centred care environments and potentially reduce levels of restriction (Alzheimers Disease International, 2015). Although dementia

does not discriminate between men and women (Newman & Price, 2012), women are disproportionately affected as previously described because age is a significant risk factor for dementia and most older people are women. Despite this over representation in terms of people with dementia and carers, women are underrepresented in terms of researchers, policy makers and practice leaders – which may partially explain an absence of attention to gender across many research studies (Averett et al. 2012).

2.7 Limitations of this Literature Review

There are significant gaps in the literature, particularly in relation to the UK and restrictive intervention practice with people with dementia, and globally in relation to qualitative dementia and restrictive intervention studies (Department of Health, 2014). A number of the reviewed studies relied on self reported experiences and self reported incidents. The views of non-respondents were therefore not known and weakened the credibility of results. Studies which included triangulation with observation or qualitative enquiry would potentially strengthen the evidence base. Additionally, as noted earlier, the legal and policy context for restrictive intervention practice across multiple countries is often different and sometimes unknown – these issues made the process of review and synthesis more challenging and arguably less reliable.

2.8 Conclusions.

The literature review aimed to understand what is known about the nature of restrictive intervention management by health care workers for people with dementia. The review found that the evidence base is limited, particularly in relation to qualitative research with staff. Two qualitative studies were included in this review,

both were based in the UK and involved staff participants (Duxbury, 2013; Macdonald, 2007). Staff education and supervision appear to have a positive impact in terms of enabling the reduction of restrictive interventions with people with dementia. Further qualitative research is indicated to explore how staff learn and how they can be enabled to deliver least restrictive practice.

The multiple roles of women in relation to dementia (formal carer, informal carer, person with dementia) suggest that women are disproportionately affected and that dementia is a gendered issue (Alzheimers Disease International, 2015). The studies considered here have factually reported gender in terms of numbers (women significantly outnumbering men in terms of participants) but have not explored the significance of gender and dementia. Gender and the lack of attention to it, in relation to restriction use with people with dementia, warrants further exploration.

Although comparison across the studies is challenging, the review did enable engagement with the evidence base in relation to restrictive intervention practice and people with dementia (Wang & Moyle, 2004). The synthesis and conclusions demonstrate the limited appreciation of the complexities of restrictive interventions with people with dementia and how to support care staff to deliver person-centred care in very challenging working environments. There were no studies, particularly of a qualitative nature, that explored the experiences of staff to improve our understanding of restrictive intervention practice in dementia care settings.

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Chapter Three: Methods

3.1 Aims, Objectives and Research Question.

Having identified a gap in knowledge in the previous literature review chapter, this chapter seeks to describe the study framework by considering the epistemology, research methodology, design and methods used for this study.

The aim of the study was to understand the management of restrictive intervention practice by mental health workers in an acute mental health setting for people with dementia, in the context of complex practice challenges and evolving policy and law. The objectives were to explore how knowledge is used by mental health workers in terms of restrictive intervention practice and how the personal characteristics of people with dementia relate to restrictive intervention practice.

Two groups of staff were interviewed. 18 frontline mental health workers and five practice leaders were interviewed using vignette based, semi structured interviews. Data was analysed using a thematic framework, informed by interpretive description and phases of analysis (Braun & Clarke, 2006). Both NVivo 10 and manual analysis were utilised to identify codes and develop themes.

The research question was:
What factors shape restrictive intervention management by mental health care workers in an acute mental health setting for people with dementia?

3.2 Epistemology: Social Construction

The qualitative research methodology chosen for this study was epistemologically located in interpretivism – seeking to understand the nature of social meaning (Silverman, 2010). The chosen method of semi- structured interviews was designed to give a voice to social action, facilitating exploration and disclosure. This approach enabled the participants in this study to discuss experiences of restrictive intervention practice by providing a structure whilst enabling exploration. This research was therefore constructionist in terms of ontological understanding, a viewpoint which acknowledges socially produced phenomena which are evolving rather than fixed (Bryman, 2012; Evans, 2000; Ritchie & Lewis, 2003; Silverman, 2010).

The study utilised research theory, restrictive practice legislation, policy guidance and empirical evidence to provide a study framework – enabling an understanding of restrictive intervention practice with people with dementia, outlined in Figure 3.1.
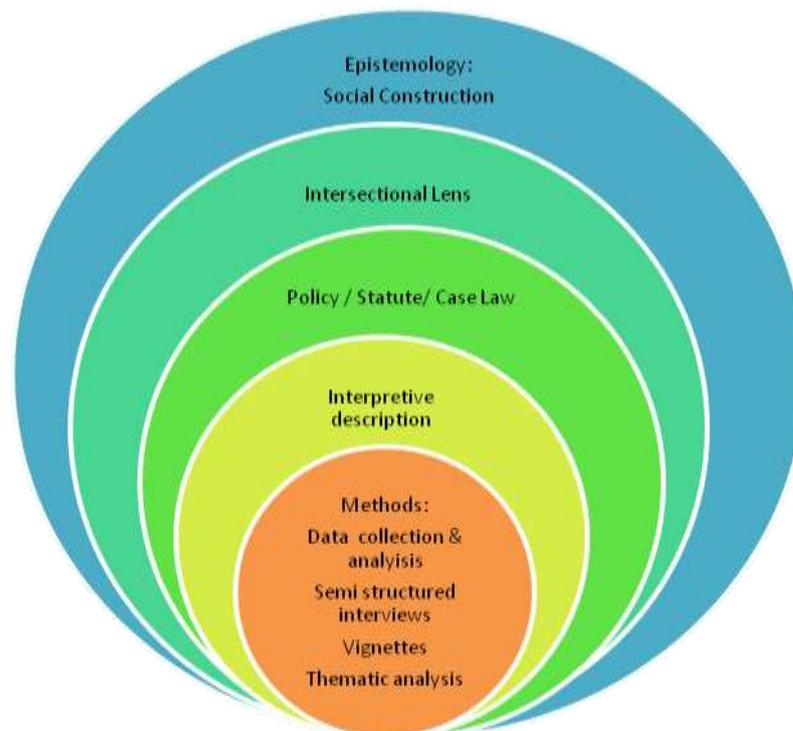
Figure 3.1: The study framework.

The inductive approach to this study was reflective of the complex environments in which the research took place in terms of experience, social location and power dynamics (Hankivsky, 2014; Neergaard, et al. 2008). The use of an 'intersectional lens', within a broader qualitative framework facilitated an understanding of social processes and social locations: enabling the interpretation of the interview data (Braun & Clarke, 2006).

3.3 Intersectionality

The methodology for the study was informed by the concept of intersectionality as it seeks to explain the way in which socially constructed differences interact to create a social hierarchy. It supposes that there is no simple experience of an identity. For example, rather than understanding restrictive intervention practice for people with dementia and staff through a single lens of gender it is necessary to consider multiple social categories such as age, experience, education and professional status. This approach positively links research and practice and is therefore compatible with interpretive description as a methodological frame (Walby et al. 2012). An increased understanding of the importance of social diversity, enables the experience of dementia to be seen as socially constructed. There are cumulative disadvantages in the experience of dementia: gender, sexuality, physical disability, race and poverty. The intersection of these characteristic defines the experience of dementia and also the experience of care giving for people with dementia (Westwood, 2016).

Intersectionality has been described in various ways (Brown, et al. 2013; Choo & Ferree, 2010; Hankivsky, 2014):

- As a research method: an integral component of a methodological framework which considers the experiences of marginalized groups (such as people with dementia).

- As a 'lens'- to reveal and understand connections and structures – encouraging exploration rather than assumption (adding rigour to the process of thematic data analysis).

- As an explanatory structure – challenging assumptions and strengthening a reflexive approach.

For this study, I sought to utilise intersectionality as an explanatory structure which facilitated an understanding of people in the context of social status or location. This structure enables an understanding of the issue of gender but also acknowledges that there are profound differences *among* women and men – not simply *between* them (Brown, et al. 2013; Hankivsky, 2014). The broad nature of intersectionality as a theoretical perspective suggests compatibility across numerous traditional qualitative research methods – including interpretive description which was used here (Choo & Ferree, 2010; Hankivsky, 2014).

As discussed in the earlier background chapter and literature review, dementia is an issue for women – but not exclusively so (Ludwin & Parker,2015). Therefore, it felt appropriate to adopt an intersectional (encompassing gender) informed perspective whereby the role of men with dementia and men as carers is acknowledged but women as a majority are 'seen'. Two central tenets of an intersectional approach

relate to the exploration of gender and power – women's lives being worthy of reflection.

Despite intersectionality shaping my own understanding of dementia, the importance of the concept was challenged and altered by my experiences in the field, as I interviewed participants whose experiences were framed and understood differently. This difference is an important issue which I will return to later, in the discussion chapter.

3.4 Interpretive Description

Interpretive description was developed in the nursing field by Sally Thorne (Thorne et al.1997) and seeks to construct a framework for the generation of practice based knowledge. It offers a pragmatic and structured 'borrowing' from other qualitative methodologies: grounded theory, phenomenology and ethnography to enable the study of applied health and clinical problems (Hunt, 2009; Morse & Chung, 2003). In relation to this study, I chose to use interpretive description because it offered an approach which works within the chosen epistemological and study framework (Figure 3.1) and is designed to explore and explain practice. This broad approach was also compatible with my own perspectives as a researcher (a nursing background, qualitative and reflexive research experience) and facilitated an understanding of the social processes relating to restrictive intervention management in gendered environments (the population of people with dementia, healthcare settings).

Methodologies, such as interpretive description, which are less distinct and draw on the strengths of others may be criticised as lacking in precision which in turn may

impact on rigour (Denzin & Lincoln, 2011; St George, 2010). Conversely, it may be argued that the interpretive description approach emphasises the constructed nature of human experience and is therefore pertinent to studies which seek to explore and understand (Thorne et al.1997). In relation to this study, the interpretive approach was relevant in a number of ways. It enabled a clinical understanding of explicit practice areas (restrictive interventions) as interpretive description specifically aims to produce findings which are persuasive and relevant to practising professionals. The approach supported the use of interviews and vignettes because interpretive description allows flexible data collection methods. It seeks to explore issues which are not readily addressed by more rigid methodologies and is also congruent with the thematic data analysis process described by Braun and Clarke (2006)

Figure 3.2. Interpretive description – the application to the methods used in this study:
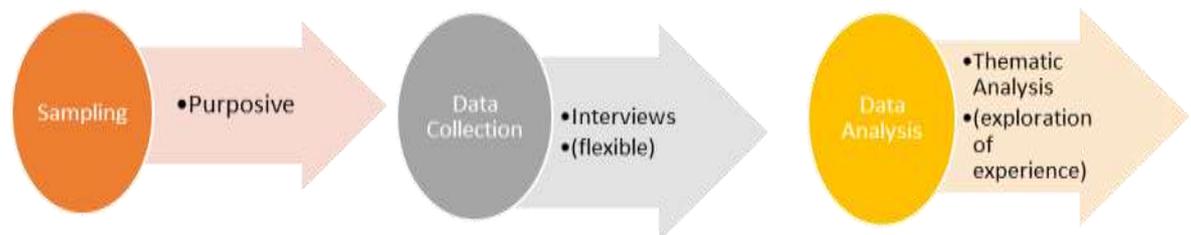
3.5 Methods – Groups 1 and 2

A qualitative cross-sectional research design was used, involving two distinct populations. Following the development of qualitative tools, semi-structured interviews were held with mental health workers and then practice leaders (Table 3.1).

Table 3.1: Research stages

Stages of research	Research tasks and processes
Group 1	Interviews with mental health workers (non-registered and registered professionals)
Group 2	Interviews with practice leaders

The relatively small size of this qualitative study and the complexity of the topic have guided the choice of methods. This section of the chapter will give an overview of methods and an outline of the analysis process that was undertaken.

3.5.1 Group One: Semi structured Interviews with mental health workers

3.5.1.1 Population

Group one participants were mental health workers (non-registered health care assistants and registered health mental health workers: nurses, occupational therapists, physiotherapists, doctors, speech and language therapists) working as, or in support of, in-patient staff. All mental health care workers assigned to the dementia wards or supporting the dementia wards in a specialist capacity were considered as potential participants (this equated to five wards and a staff group of approximately 250).

3.5.1.2 Sampling and recruitment

Group one used a purposive sampling approach (the sampling frame was all mental health care workers rostered or linked with two dementia wards managed by an NHS Trust). Posters outlining the research were sited in in-patient areas and I attended team meetings to outline the research. Initial contact with prospective participants was made via the Matrons (delegated to Ward Managers) who were asked to

facilitate the sending of letters to mental health care workers within the accessible population. I coordinated individual discussions with Matrons and Ward managers to stimulate interest in and understanding of the research. Those mental health care workers interested in participation were asked to contact the researcher directly by returning a pre-populated response slip (Appendix 6).

3.5.1.3 Use of 1:1 semi-structured interviews: rationale

Given the complex policy guidance which framed restrictive intervention practice, the flexibility afforded by semi-structured interviews was appropriate to this research: it allowed the participant and researcher to flexibly introduce unanticipated material. The participation of myself as the researcher was valued, analysed and acknowledged as socially and contextually relevant within the interview process. This semi-structured interview method has been evidenced as an effective vehicle for exploring socially constructed processes within a qualitative approach (Braun & Clarke, 2013; Bryman, 2012).

3.5.1.4 Preparation of interview schedule and vignettes

To explore methodological feasibility, a semi-structured interview schedule (Appendix 7) was tested with two registered mental health workers, evaluating the flow of the structure, which enabled revisions to be made. Central to the semi-structured interview process was the development of fictitious vignettes, which were informed by a methodological literature review (Appendices 8 & 9). Within qualitative research, vignette content is constructed cautiously, to avoid closing down the responses of participants. It should reflect everyday practice, avoiding extremes and complexity: providing sufficient elements to enable an understanding of the context but avoiding intricate detail which may serve to distract from an exploration of beliefs. Vignettes are commonly used as tools to aid the interview process but for this research they

provided the structure of the interviews and were therefore developed carefully. There was an opportunity to develop interview discussions by using questions which were related to the vignette stories. I structured the vignettes in a logical way, introducing the protagonist (a service user) and characteristics to be explored - identifying these characteristics from evidence-based literature (outside of my own literature review), case law and practice guidance (Barter & Renold, 1999; Cresswell, 2009; Richards et al, 2007).

Published studies which consider the use of vignettes within qualitative research suggest that comparisons may not be accurately drawn between expressed beliefs (within the research) and actual actions in practice (Bryman, 2012; Ludwick et al. 2004; Wang & Moyle, 2004). To mitigate against this limitation of the method, the content of the interview discussion within this research facilitated participant choice, allowing responses which describe actions in the third person (the action a mental health care worker may have taken in theory) and the opportunity to introduce participant experiences and viewpoints (Barter & Renold, 1999; Cresswell, 2009).

The structure of a vignette may range from a single sentence description of a scenario – followed by a closed question to facilitate the coding of responses, to a complex outline of a scenario which introduces a number of elements and variables. Vignettes coupled with open ended questions enable the participant to define the meaning of a given scenario. While this offers flexibility, it may also reduce the researcher's ability to draw comparisons in relation to the responses of different participants, impacting on the potential for analysis (Finch, 1987; Peabody et al. 2004). This study consulted clinical mental health workers in relation to the content development of vignettes, guided by a number of health studies which have validated this approach as it supports the construction of scenarios which resonate with participants as understandable and realistic (Braun & Clarke, 2013; Peabody et al,

2004). The use of vignettes which have been developed with mental health workers aligns with the epistemological framework of the study and interpretive description - social construction and interpretive description acknowledging that knowledge is jointly generated by the researcher, the participant and previous research (Hunt, 2009).

In this study, the use of service user characteristics within the vignettes was systematically varied to enable an intersectional discussion (exploring age, gender, physical ability). This construction assisted the data analysis to consider vignette characteristics and associated participant responses (Frayne, 2004). Limiting the number of elements has been shown to facilitate the depth of participant responses which was appropriate to the explorative nature of this study (Chambers & Thompson, 2008; Hagvide et al. 2013).

The literature suggests that a number of limitations exist in relation to vignettes. Participant assumptions and views may not be fully tested if they are 'filtered' via a vignette. Study evaluations have confirmed a relationship between participant beliefs, actions and vignettes and advise that vignette-based research findings may require caution in interpretation (Barter & Reynolds, 1999; Chambers & Thompson, 2008; Hagvide et al. 2013). In relation to this study, this risk was mitigated by participants being given the opportunity to discuss their own experiences and practice examples alongside the vignette method. The use of vignettes as the structure within the interviews enabled discussion with participants but also further challenged the use of intersectionality as an explanatory structure for the research. The way participants responded to the vignettes will be discussed in more depth in the discussion chapter, considering the 'vignette effect' on the process of analysis and findings.

3.5.1.5 Conduct of interviews

The semi-structured interviews lasted for approximately 30-60 minutes each and data was digitally recorded and transcribed verbatim. Audio recordings were stored securely and sent electronically in encrypted files to the transcriber (a transcription company was utilised which has a confidentiality agreement with the host NHS Trust – Appendix 10). The audio recordings did not contain any personal identifiable data (participants were identified by a unique number system for the purposes of data analysis).

3.5.2 Group two: 1:1 Semi-structured interviews with practice leaders

3.5.2.1 Population

Group two interview participants were recruited from a pool of practice leaders who supported the dementia in-patient services provided by the host NHS Trust. The group of potential participants were identified by the Matrons with reference to the specialist roles and functions provided by the organisation.

3.5.2.2 Sampling and recruitment

Group two interview participants were sought as specific sources of clinical experience and leadership (senior clinical and practice roles, involved with dementia in-patient environments). 18 potential participants were identified via the Matron Managers to avoid issues of influence and coercion (if I had contacted staff directly). The sampling method was designed to be sequential rather than fixed; if necessary, it would have been possible to add additional interviews to the sample if participants withdrew – in practice, this was not necessary as there were no withdrawals (Carter & Henderson, 2005; DoH, 2005; Hyde et al. 2005).

As with Group 1 recruitment, posters outlining the research were sited in in-patient areas. Initial contact with prospective participants for group two was facilitated via the Matrons.

Those recruited were lead professionals: Nursing, Medicine, Allied Health Professionals, Training leaders.

3.5.2.3 Data collection

As with group one, a semi-structured interview schedule (Appendix 11) was tested with two registered mental health workers and semi structured interviews were then conducted, each lasting for approximately 60 minutes. Data was digitally recorded and transcribed verbatim. The audio recordings of the group two interviews were stored securely by the researcher and sent electronically in encrypted files to the transcriber (the same transcription company was utilised which has a confidentiality agreement with the host NHS Trust – Appendix 10).

The interviews with practice leaders explored the policy and strategic frameworks which govern the management of restrictive interventions in mental health care environments.

3.6 Data Analysis

3.6.1 Data analysis (Groups one and two)

Interpretive description lends itself to an exploration of practice and social processes and within this research, an intersectional approach enabled the understanding of the nature of restrictive intervention management in complex environments. A thematic analysis was undertaken sequentially for two sets of data (group one: semi-structured interviews with mental health care workers, group two: interviews with policy and practice leaders). This approach sought to reveal the meaning in the accounts of

mental health care workers and to understand the connections between those accounts and their context in relation to restrictive intervention management (Bryman, 2012; Riley & Hawe, 2004; Thompson & Dowding, 2001; Thompson et al. 2006). Qualitative data analysis is increasingly systematic in its approach, while retaining creative possibilities which enable an understanding of social experience (Ritchie & Lewis, 2003; Silverman, 2010; Starks & Trinidad, 2007). The data analysis for this study was undertaken using a computer software aided (NVIVO 10) package, supported by manual techniques of data coding and review to ensure attendance to detail and nuance. This process entailed my reading and re-reading of the interview transcripts, the allocation of codes and the formation of sub-themes and themes. This practice was iterative: the data was revisited and refined as the analysis deepened. This approach to data management and analysis enabled me to engage in both overt processing and original innovation (Braun & Clarke, 2006; Bryman, 2012; Denzin & Lincoln, 2005; Patton, 1999; Silverman, 2010). The volume of data generated by this research was considerable. A transcribing service was commissioned to pragmatically address this challenge, acknowledging that an opportunity for data immersion at the transcription stage of analysis was lost (Braun & Clarke, 2013; Bryman, 2012). This loss was mitigated by repeated review of audio transcript files and reading of the transcripts.

3.6.2 Analysis framework

Thematic analysis offers a method which is not exclusively relevant to any particular theory or approach and in relation to this study, thematic analysis was utilised as an explicit method of analysis. The process of identifying patterns and themes and making analysis decisions is acknowledged and owned using a reflexive approach.

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The thematic analysis was framed by the six phases described by Braun & Clarke (2006). This model was not applied as a linear approach - phases were repeated to facilitate new ideas or reinterpretation of data.

Table 3.2: Phases of thematic analysis (Braun & Clarke, 2006)

Familiarisation with the data
Audio recordings were listened to. Transcriptions were read and re-read, checking accuracy with audio recordings and interview notes. Notes were made each time the data was engaged with.
Coding
Data items were coded (ensuring that sufficient data was included to retain the context). The coding aimed to capture both what was being said and how it was being said. The collation of codes and extracts exemplars enabled the analysis to progress.
Searching for themes
Themes were actively constructed as codes were built into more meaningful structures which were relevant to the research question. All coded material was allocated to a theme or placed in a 'miscellaneous' theme.
Reviewing themes
Data was 'sense checked' against the analysis to date to ensure that the themes represented the codes and that the full data set provided a coherent narrative. Some themes were collapsed, others were created.
Defining and naming themes.
The scope of each theme was defined and described.
Writing up.
Findings associated with each theme were reported on.

3.6.2.1 Familiarisation with the data

Following each interview, reflective notes were made and were then utilised alongside the interview data to make sense of what I was hearing, aiding coding and interpretation. Transcripts were reviewed for accuracy against audio files and then re-read in hard copy. The reflective notes were then augmented to capture

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developing thoughts and ideas. From the outset, there was a conscious owning of the analysis – an acknowledgment that themes did not organically 'emerge', they were constructed by me as the researcher (Braun & Clarke, 2006).

3.6.2.2 Coding

Some potential coding ideas were already noted (via my research knowledge and experience, the review of the literature and a coding pilot of two of the transcripts). The full initial coding exercise reviewed each transcript line by line to create a comprehensive coding chart containing 143 codes (Appendix 12). This initial process was completed manually to allow detailed close engagement with the data – before loading the coding framework onto NVivo 10.

3.6.2.3 Searching for themes

The initial coding enabled the development of categories and sub themes. These were revised and reconstructed to create seven potential or candidate themes (holding 131 codes) and one miscellaneous theme (holding 13 unassigned codes) (Appendix 13).

3.6.2.4 Reviewing themes

The subsequent use of Nvivo 10 allowed rapid and repeated access to all data associated with each potential theme and to the entire data set. Phases five and six of Braun and Clarke's (2006) model are addressed in later Chapters. The names, definitions and scope are interpreted in the Discussion Chapter.

3.7 Credibility and Rigour

The notion of rigour or truth value is traditionally associated with the concepts of reliability and validity which are rooted in quantitative research traditions: the convincing application in qualitative methodological design is more challenging. For this study therefore, it was essential that the analysis process, from piloting to initial coding to thematic formulation was transparent and auditable. This was enabled via grouped data collection (allowing contrast and comparison), an overt approach to data management, and the use of computerised and manual analysis. These approaches all inject rigour into the research process by enabling the reader to scrutinise the methodological approach (Bryman, 2012; Carter & Henderson, 2005). This tangible credibility is enabled by the interpretive descriptive approach which pragmatically frames this study and the intersectional lens which examines its findings (Hankivsky, 2014; Thorne et al. 2004).

The concept of triangulation is usually thought of in mathematical terms meaning to locate an unknown point by measuring angles to it from other known points. It is possible however to relate this to qualitative research by acknowledging that it can be helpful to utilise different perspectives to examine the same phenomenon (Denzin and Lincoln, 2011). The participant groups within this research, the links to contextual restrictive intervention benchmarking data and evidenced based literature provide several sources of information to progress a robust understanding of restrictive intervention management.

3.8 Reflexivity

The methodological framework outlined for this study required that I took a reflective and reflexive stance as a researcher (reflectively via a process of introspection, reflexively by attempting to examine interactions as they occurred). This stance

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required an overt and continual questioning of the process and my position within it (Berger, 2013).

In practical reflection terms, I have maintained a reflective journal which consists of notes following interviews, references to books and articles of interest, notes of conversations with clinical and research colleagues and my own developing thinking. The process of reflective writing is dynamic in that it both captures and stimulates new thinking. This dynamism was of particular relevance to the findings and discussion chapters as I sought to link the literature to findings and then to explanatory theories and frameworks. As this reflective process has developed, my awareness of the fluidity of my own identity has grown – in that I accept that it is contextual and shifting.

Box 3.1. An example of a reflective journal entry

Reflection (present tense).

I am an employee of the host NHS Trust working in a senior management role. I am a registered nurse (mental health and adult nursing) and my own practice history largely relates to the care and treatment of older people and particularly with people with dementia. As I develop the research protocol, I am conscious of the need to reflect on my role as a researcher (and a Trust manager) and the impact of that on participants. I am aware that there may be an impact on recruitment strategies – will staff feel comfortable to take part?

I do not have management responsibility for ward based services or line management relationships with ward based staff – but it would be naive not to acknowledge the power issues that may exist. During interviews, I will need to reflexively recognise and respond to power issues as interactions take place.

The examination of myself as a researcher, a mental health worker and an individual has been challenging and uncomfortable at times but is a key element of quality control in a qualitative project (Gerstl et al, 2009; Gibbs, 1988; Muller, 1993). For example, my position as a manager within the host NHS Trust required careful consideration during the recruitment and interview process to guard against any coercion or threat (real or perceived). Additionally, my distance from practice reality demanded a greater level of acknowledgement, attention and study than I had anticipated. This awareness of a layered identity has strengthened my belief that an intersectional lens is essential to this study (McDonald, 2013).

Reflexivity is more challenging to conceptualise and evidence and is not without criticism. It is sometimes regarded as a 'double edged sword' because of the potential for subjectivity and ambiguity. I have tried to approach the research in an open and transparent way, acknowledging my own practice background and beliefs about people with dementia during the research process and when reporting its outcomes (Doyle, 2013; Etherington, 2004). In relation to this project, the reflexive position was essential – harnessing these criticisms and positively utilising them to understand the positioning of myself as a researcher within a broader review of the socially constructed world (Finlay, 2002). Figure 3.3 illustrates the reflexive cycle - which 'closes the loop' – forming a cycle of continuous feedback.

Figure 3.3: The reflexive cycle (adapted from Gibbs (1988)):

Researcher position:
My values and beliefs and assumptions

Reflexivity

Research Process: the study

Reflexivity
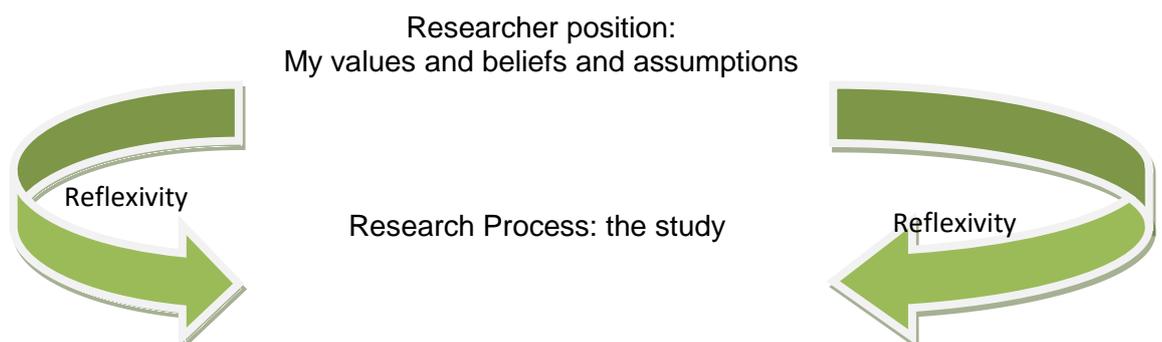
3.9 Ethical issues

Lancaster University ethical approval was initially required, followed by governance approval from the host NHS Trust (via the Research and Development Department). Trust approval entailed the setting up of an accessible Trust file which included a risk assessment which was accessible to all participants on request.

The specific areas of concern for the study were:

- Anonymity and confidentiality (due to the small sample of participants)

- Mental health worker concern and distress when discussing sensitive issues relating to restrictive interventions

- The power differential between myself as the researcher (and senior manager) and participants

Data protection and confidentiality were central to the ethical credibility of the study and to the management of the specific ethical issues. The Data Protection Act (1998) informed this process providing a framework for data management and protection of participants. The ethics applications to both Lancaster University and to the NHS Trust were aligned to The Data Protection Act (1998) and given that the small sample sizes which were recruited from discrete clinical areas, the issues of anonymity and confidentiality were challenging (participants may be identifiable by their Trust role if disclosed during interviews).

To mitigate against the anonymity and distress concerns, participants were provided with a participant information letter, participant information sheet and a participant consent form (Appendices 6,14,15) at an information session or by letter and email. These documents sought to realistically describe the risks to participants while detailing the benefits of participation and guided participants to support resources in the

event of distress (British Psychological Society, 2010; Hancock et al. 2009). Consent was verbally re- checked at the commencement of each research element (group one and two interviews) and confirmed verbally via the digital recording process. Demographic data was also requested from each participant which all agreed to provide (Appendix 16).

The study was ethically framed by the Lancaster University Research Ethics and Research Governance Code of Practice. Additionally, the ethical principles have been informed by an ethical grid (Seedhouse, 1988) (Figure 3.4). The ethical grid provides a tool for health care workers to frame decision making and reasoning. This study was considered in the context of the grid from the formulation of the research question and throughout the research process as it helped to align the study to practice. The utilisation of this tool links to an interpretive descriptive approach (a method which stays close to the complexities of the practice context) and has enabled my reflexive approach by providing a concrete challenge to my decision making (Seedhouse, 1988). The centre of the grid was helpful in terms of aligning my ethical thinking to Group one (mental health workers) priorities while the outer sections enabled ethical thinking in terms of the priorities of Group two (practice leaders) during both data collection and analysis.

Figure 3.4: The ethical grid (Seedhouse, 1988).

Resources available

Effectiveness and efficiency of action

Most beneficial outcome for the individual

Wishes of others

The risk

Keep promises

Most beneficial outcome for society

Do most positive good

Respect persons equally

Create autonomy

Respect autonomy

Tell the truth

Most beneficial outcome for oneself

Serve needs first

Minimise harm

The law

Codes of practice

Most beneficial outcome for a particular group

Disputed evidence/facts

The degree of certainty of the evidence on which action is taken

This study was also ethically influenced by the Nuffield Council on Bioethics publication, Dementia: ethical issues (2009) which encourages research which supports health care workers to understand and respond to people with dementia.

3.10 Conclusion

This chapter has outlined the research process, illustrating an alignment to the methodological framework. The research question and objectives were at the core of this study which was driven by practice complexities which are experienced every day in dementia care environments. The methods described in this chapter were developed in discussion with mental health workers and after repeated reflection in relation to their authenticity and efficacy (Mauthner & Doucet, 2003; Newton et al. 2011). The first four stages of Braun and Clarke's (2006) thematic analysis process

were addressed with the final phases being considered in the next chapter. During the process of analysis, I risked being blinkered or influenced by my own perceptions, experience and knowledge of the relevant literature. To moderate this risk, my reflexivity was integral to the methodological framework, approaches and research practice.

The adoption of an intersectional perspective described earlier in this chapter is an example of an ethical and reflexive and evolutionary approach to the study - it provided a lens which sought to understand the broad range of characteristics which shape humans – both within and between genders – seeing people, including myself, as multidimensional (Hankivsky, 2014). In the following chapters, the findings of the study are described and discussed within the flexible framework offered by interpretive description (Thorne et al. 2004).

Chapter Four: Findings

4.1 Introduction

This chapter aims to present an overview of the findings from the study – providing an account to understand the experiences of the participants. The chapter will outline the key themes which have been developed in response to the research question and objectives. The chapter also contains a number of extracts of participant data which are used to exemplify the key themes which were:

- Legislation and practice

- The structures provided by the NHS Trust

- Training and supervision

- Person-centred care and restrictive interventions

As discussed, the thematic analysis for this study used the six phases described by Braun & Clarke (2006) and this chapter will focus on phases five and six of the process: defining and naming the themes and writing up. The themes described in this chapter have been defined via a process of coding and organising of participant data, seeking an understanding of the fundamental meaning of each theme. The process of reviewing and defining themes enabled the collapsing and amalgamation of themes over five phases of coding review – progressing the alignment of themes to the essence of the research question (Table 18 below).

The participant data was finally brought together under four main themes which this study identified as areas which shaped restrictive intervention practice by mental health staff working with people with dementia. The findings from mental health workers and practice leaders were considered separately and then merged as themes were found to be shared.

4.2 Context of Findings

Eighteen group one participants and five group two participants were recruited which provided a sample containing a range of ages, professional groups and both men and women (Table 4.1). In group one, 12 participants were female, six were male. In group two, one participant was female, four were male. Across both groups, 20 participants were registered mental health workers (nurses, speech and language therapists, physios), three participants were in non-registered roles (health care assistants). The ages of participants interviewed ranged from 25 to 54 years and all participants worked for the same mental health NHS Trust. Fourteen of the group one participants worked in the hospital on Site one, five worked in the hospital on Site 2. In terms of ethnicity, all participants were white and 22 of 23 participants were British.

Table 4.1: Participant characteristics

Group 1: Mental health workers					
Participant Number	Age in years	Profession	Gender	Ethnicity	Hospital sites
1.0	50	Registered mental health worker	Female	White British	Site 1
1.2	44	Registered mental health worker	Male	White British	Site 1
1.3	50	Registered mental health worker	Female	White British	Site 1
1.4	50	Registered mental health worker	Female	White British	Site 1
1.5	54	Registered mental health worker	Female	White British	Site 1
1.6	45	Registered mental health worker	Male	White British	Site 1
1.7	39	Registered mental health worker	Male	White European	Site 1
1.8	53	Non- Registered mental health worker	Male	White British	Site 1
1.9	29	Registered mental health worker	Male	White British	Site 1
1.10	34	Registered mental health worker	Female	White British	Site 1
1.11	33	Registered mental health worker	Male	White British	Site 1
1.12	50	Registered mental health worker	Female	White British	Site 1
1.13	25	Registered mental health worker	Female	White British	Site 1
1.14	50	Registered mental health worker	Female	White British	Site 2
1.15	52	Registered mental health worker	Female	White British	Site 2
1.16	56	Registered mental health worker	Female	White British	Site 2
1.17	28	Non- Registered mental health worker	Female	White British	Site 2
1.18	29	Registered mental health worker	Female	White British	Site 2
Group 2: Practice Leaders					
Participant Number	Age in years	Profession and role	Gender	Ethnicity	
2.1	42	Registered practice Leader	Male	White British	Sites 1 & 2
2.2	50	Registered practice leader	Female	White British	Sites 1 & 2
2.3	50	Non registered practice leader	Male	White British	Sites 1 & 2
2.4	51	Doctor	Male	White British	Sites 1 & 2
2.5	48	Doctor	Male	White British	Site 1

4.3 An Overview of Themes and Sub Themes

Four themes and 18 sub themes were identified (Table 4.2).

Table 4.2 Overview of themes

Theme 1	Sub-theme
Legislation and practice	The law does not always frame practice
	The law is a mess
	Practice before the MCA
	Making sense of the legislation
Theme 2	
NHS Trust Structures	Risk policies
	How staff manage risks to themselves
	Activity can reduce risk
	The role of medication
	The care environment
	The importance of time
	How training is structured
Theme 3	
Training and supervision	The restrictive intervention strategies used by staff
	Different roles
	Reflection and supervision
	Emotion and the caring role
Theme 4	
Person-centred care and restrictive interventions	Each person is an individual
	Communication and uniforms
	Getting to know the person
	Care planning for person-centred care

The themes are presented above (Table 4.3) and below in an order which reflects the 'stepped journey' of knowledge which enabled an understanding of legislation for frontline mental health workers (reflecting my analysis of the participant data and illustrated in Figure 4.1), the theme of legislation being presented first. Each theme is discussed (identifying sub-themes to facilitate detailed description) and illustrated by participant quotes which have supported the process of analysis and interpretation. The four themes identified relate to both group one and group two, albeit from different perspectives. The vignettes provided basic and limited details about a person with dementia – during interviews the participants sought further detail or expanded the vignette themselves to enable the theoretical discussions which suggested an interest from both groups to understand the 'stories' of people with dementia.

As findings are described under thematic headings, group one participants will be referred to as mental health workers and group two participants will be referred to as practice leaders. The chapter will describe each theme in turn and make reference to the role of practice leaders as translators. Figure 4.1 below illustrates the story that the themes tell – how knowledge progresses from legislation to practice and vice versa. The knowledge journey is not necessarily one directional but complex and multi-faceted. Practice leaders may learn from mental health workers who in turn may learn from people with dementia.
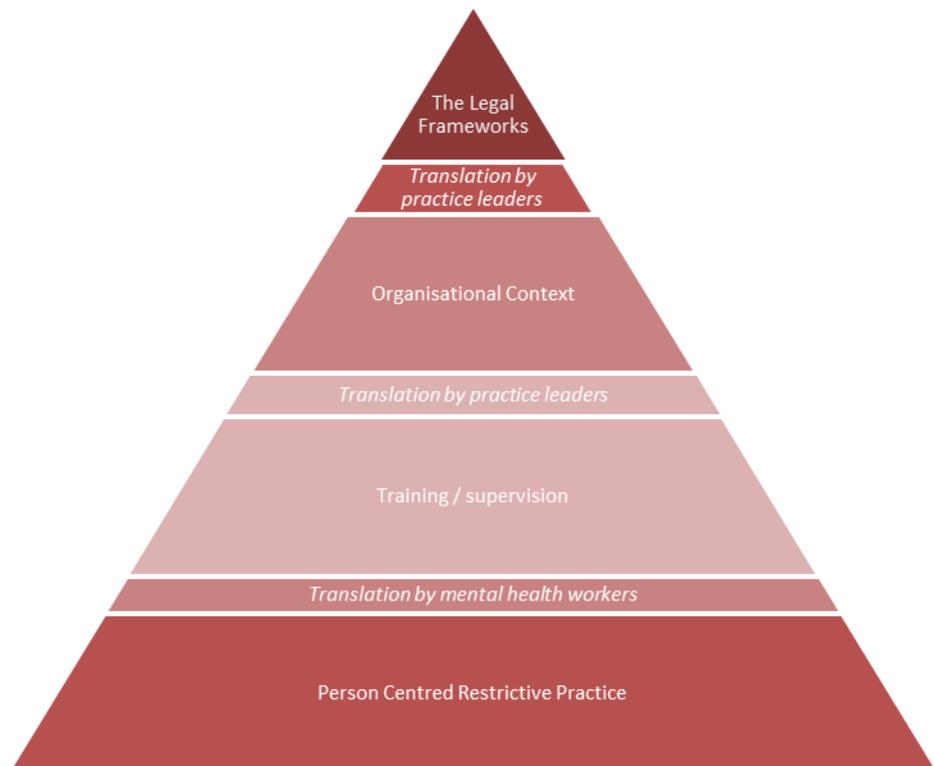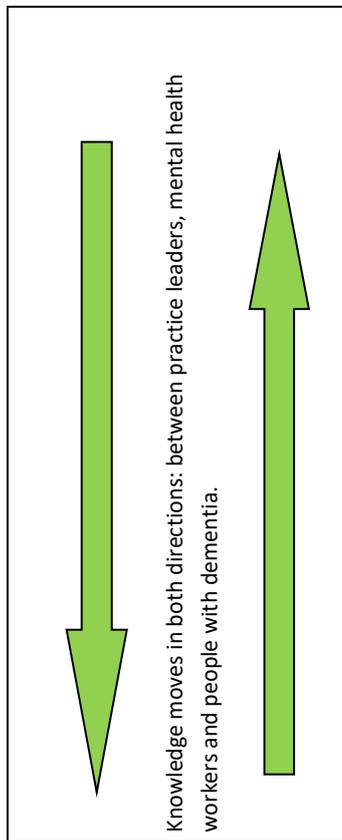
Figure 4.1: The four themes and the points of translation of knowledge.

4.3.1 Theme One: Legislation and practice

The first theme addresses how participants described the legislation which frames restrictive intervention practice. This theme was central to the role of practice leaders but peripheral to the everyday challenges of restrictive interventions as described by mental health workers (three mental health workers referred directly to legislation).

4.3.1.1 The law does not always frame practice

There is a myriad of legislation which framed practice for participants in their work with people with dementia: the Mental Health Act (2007), Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (2007). The NHS Trust which hosted the study had invested in a number of lead practice and practice development roles (five of whom are group two participants). Mental health workers told me that legislative frameworks (particularly the Mental Capacity Act and Deprivation of Liberty Safeguards) were difficult to understand. They repeatedly described practice approaches which were person-centred and least restrictive, but most did not frame their practice explanations within a legislative rationale. Mental health workers frequently referred to the use of least restrictive practice to enhance the well-being of people with dementia and to minimise the use of more invasive restrictive interventions. They were able to give examples of this when they responded to vignette-based discussions.

> *'whatever happens...it will be in his best interests. That would include the least restrictive approach to any of his needs'* (Participant1.7)

Participants also described an understanding of the impact of admission and associated restriction for a person with dementia. Again, the descriptions were not framed by legislation but by person-centred care principles.

A mental health worker participant described an awareness of the impact of admission:

> '*I've always been very clear about making sure that you have a huge appreciation of liberty, because as staff we get to walk out of the door*' (Participant 1.2)

Practice leaders described a changing use of legislation across both mental health hospitals included in the study in response to emerging case law. This was described as favouring the use of the MHA (2007) when treating people with dementia in mental health hospitals. This increasing use of the MHA (2007) was further described by other participants - in one of the hospitals, all service users with dementia who lacked capacity were detained under the Mental Health Act and in the second hospital, an increasing use of the Mental Health Act was described.

This changing practice was specifically acknowledged by a registered mental health worker:

'In the area that I work, I've never had anybody here on a DoLS. It's always been either informal - they have capacity. If they don't have capacity, they're detained'

(Participant 1.15)

4.3.1.2 The law is a mess

Practice leaders were critical of the legislative landscape, they described the MCA (2005) as a helpful and much needed piece of legislation which is designed to protect vulnerable people, including those with dementia, but explained that it is not well understood by mental health workers and therefore not well utilised to enable least restrictive practice. Practice leaders were more critical of DoLS (2009), they described the legislation as complex, shifting and unwieldy and requiring translation for practice.

One of the practice leaders commented:

'I think we make it really difficult for our staff. At the front line I think this is forever going to be a minefield.....some key individuals have done a lot of work ....finding new ways to explain it to staff.....people struggle to get it'
'They're [mental health workers] thinking much more about what they're doing and using less restrictive techniques with people but they might not necessarily be thinking about what legislative framework it fits in' (Participant 2.1)

New ways of explaining legislation to staff were described in terms of training, the development of supervision groups, assessment and care planning tools and policies written to be accessible by mental health workers.

'I think the problem is that the guidance is so huge, detailed and shifting that it's actually not very helpful.....the sheer volume of guidance coming out and the subtlety and shifting nature...I think the ward staff do understand quite well, degrees of restrictiveness...and I think in practical terms, that's probably the most important thing' (Participant 2.4)

The practice leaders were aware of the difficulties faced by frontline staff as new legislation has emerged. A practice leader explained:

'For years we told people that the MHA was your single piece of legislation and your guiding principle .....in the code of practice it spells it out, and that's quite easy for people to understand. To then introduce that you have the MHA and the MCA and you can use them interchangeably and maybe one is better

in some areas...I think in very inarticulate terms, it blew people's minds, it was

too complicated' (Participant 2.1)

Some practice leaders spoke in more negative terms about the legislative issues, describing them as untenable and time wasting for mental health workers. They also advised that for people with dementia, the experience of care rarely differed, regardless of the legislative framework which was utilised, because they believed that staff have a good understanding of least restrictive principles, and they apply them regardless.

'I think the law is a complete dog's dinner. When I go to tribunals, one of the

questions in the report is 'Would the MCA be less restrictive?' and I

think...that's a lawyer's question....because from the patient's point of view,

you're locked up in a ward....and it doesn't help you at all' (Participant 2.4)

Practice leaders also described the shifting nature of the legislation. One practice leader described the guidance as a pendulum, caused to swing by case law. They described that in 2016, the pendulum had swung clearly towards the MHA and structured restriction which does give clarity for ward based mental health mental health workers.

'I think at the moment...the pendulum has swung...and at the moment it's

dead easy. If you are in hospital and you lack capacity, you are detained, so I

think more people understand it now' (Participant 2.5).

4.3.1.3 Practice before the MCA

Practice leaders described practice prior to 2005 as simpler in terms of legislative frameworks. The MHA (2007) was described as being well understood by practice based staff in terms of guiding restrictive practice. I found that both groups of participants were less able to articulate how informal service users were managed prior to the introduction of the MCA (2005). Common Law was referred to but it was acknowledged that this was an undefined approach.

> *'it was either the MHA or nothing...I mean people would act but not necessarily even saying I'm doing this under Common Law, it would just be done' (*Participant 2.1)

The same practice leader went on to explain that even with the advent of less restrictive legislative options, the MHA (2007) is sometimes the chosen framework, because of the staff's experience and level of understanding, describing the use of the MHA (2007) as *'very black and white'* for frontline staff while other approaches (informal admission with consent, admissions using the MCA and DoLS) are less clear and may offer less safeguards to people with dementia and their families as the processes to enable challenge or appeal are less structured and accessible, in comparison to the MHA (2007).

4.3.1.4 Making sense of the legislation

Practice leaders were able to articulate an understanding of the legislation and explain their role in communicating that understanding to frontline staff. They described how their roles include the translation of legislation into policy, practice guidance and training content which supports mental health workers on the front line of care delivery. This is in contrast to mental health workers who described their

restrictive intervention practice as being largely based on person-centred care principles.

A practice leader described a detailed level of understanding:

> *'I think we are in a much more sophisticated and…humane culture of care delivery now…than 15 years ago and part of that sophistication …has been the by-product of introducing …the MCA and DoLS'* (Participant 2.1)

The same participant went on to describe how this level of understanding of legislation is not always applied in practice:

> *'…for all our emphasis and training on sophistication and awareness, we're still seeing it misapplied...we know from audits, serious case reviews, learning events where the application of assessing and applying capacity is still misfiring'* (Participant 2.1)

4.3.2 Theme Two: The structures provided by the NHS Trust

Theme two focussed on findings which related to the organisational policies and processes which participants described as informing restrictive intervention practice.

4.3.2.1 Risk policies

Participants discussed key policies in relation to restrictive intervention practice was that governing risk assessment and management. The local NHS Trust policy covered risks associated with harm to self, harm to others and risk in terms of vulnerability and self-neglect. Participants described structured approaches (using policy guidance), to the assessment of risk with people with dementia which in turn informed restrictive intervention practice. They explained that the risk policy provided

a framework to consider the risk associated with a service user in certain circumstances and how the safety of the service user and staff could be assured in the context of delivering care and treatment.

Mental health workers described an emphasis on assessment. They used the structure of the policy to consider physical attributes and history and then applied clinical judgement to each situation:

A mental health worker described the focus of assessment on admission:

> *'Everyone initially comes in and has fifteen minute observations...at least for the first three days at that level, and I think that gives us a fairly good idea of how settled or unsettled someone is likely to be'* (Participant 1.1)

Mental health workers also described how assessment would enable vulnerability in relation to age and frailty to be considered and were particularly concerned about skin integrity. They described an awareness of age related frailty and how that plays into risk assessment and would form part of a restrictive intervention care plan.

> *'I think when you are trying to assist an 82 year old in any way ..to the toilet..to eat..to change seating, position in bed, you are more aware of brittle bones and the fact that they might slip and there could be a greater risk of fall and a greater risk of injury and harm..we're all very aware'* (Participant 1.12)

Risks to skin were further described as complex in relation to restrictive interventions: a frail person with dementia is at risk of skin damage during physical restrictive interventions but skin integrity may be compromised if personal care is refused following an episode of incontinence. Several mental health workers discussed this during interviews when considering how they would respond to the vignette scenarios (Appendices 8 and 9).

A mental health worker described how they would respond to a scenario where the person with dementia has been doubly incontinent.

> *'There's always the issue around skin integrity...I think the preference would be for him to be changed, do body mapping if we need to, if there are any skin integrity issues'*
>
> (Participant 1.3)

Another mental health worker agreed that a threat to skin integrity would require intervention. They commented:

> *'They can't leave her in faeces and urine...so that's pretty black and white really. We need to clean her and we need to change her'* (Participant 1.1)

While mental health workers were aware and supportive of a structured approach to risk, they were clear that clinical judgement and best interest decision making is an essential part of that process. The mental health workers were registered in mental health but described an awareness of the physical health needs of service users. The same mental health worker confirmed this and advised that the clinical judgement may be - to *not* act at that time, particularly if a service user is not well known:

> *'It's clinical judgement isn't it and it's about kind of thinking, if someone is new to us, we will try and do as little as possible'* (Participant 1.1)

The importance of the relationship with the person with dementia and the relevance of that relationship to restrictive intervention practice is explored in more detail later under Theme 4: person-centred restriction.

4.3.2.2 How staff manage risks to themselves

In the context of discussions about risk, mental health workers also described risks to themselves which may be described as secondary risk management (risk to mental health workers of litigation, disciplinary action, accusation or blame). Secondary risk management does not relate to practice which protects the person with dementia but rather describes the measures taken by a mental health worker to mitigate the risk to themselves (in relation to this study, these secondary risks related to concern that service users may make accusations against staff or a service user may come to harm and blame may ensue). Male mental health workers raised secondary risk on a number of occasions in relation to their gender – they expressed concern and caution when delivering care to female service users.

A mental health worker described:

> *'I'm a male, I can't go in because...whether it's chaperones for your own safety or for the patient's point of view'* (Participant 1.2)

A second male mental health worker commented more strongly:

> *'I've always, always had a female in with me, a member of staff. I will never attend to a female patient's personal care on my own'* (Participant 1.8)

Another mental health worker offered a different view of secondary risk when they suggested that staff concerns and the management of those concerns can themselves be restrictive to a person with dementia.

> *'So I think we need to deal with our anxieties more than theirs and then they're not as restricted. Because I think that's a big restriction that goes on that people don't see as a restriction'* (Participant 1.4)

This approach to secondary risk management acknowledged that secondary risk may exist but should be named and managed overtly. Participants also described a process of reflection and self examination which allowed them to focus on the primary risk – that which is actually faced by the service user.

4.3.2.3 Innovation and risk

Mental health workers described approaches which could be adopted to reduce the level of risk (and therefore the potential need for restrictive interventions). Focussing on activity was described as important, as was knowing the person and understanding their usual level of or need for activity and trying to enable that in a ward environment. Participants described a relationship between reduced activity and increased frustration and then distressed behaviour.

A mental health worker reflected after reading the service user vignette (Appendices 8 and 9):

> *'If I was stuck somewhere, I'd like to be outside all of the time and if I was suddenly unable to, it would frustrate me'* (Participant 1.18)

Another mental health worker commented on the same vignette:

'*He needs to walk, otherwise he is going to become very frustrated and we don't need to expose him to those risks of either getting very angry, frustrated, throwing things, hurting somebody, hurting himself just because he can't do the things he would normally do at home*' (Participant 1.1)

Mental health workers also described the value of normalising the behaviour of the person with dementia – instead of seeing it as a challenge or a problem:

'*If you think about yourself sat at home, you wander into the bedroom and you might close the curtains, you might not. You might wander into the kitchen, look in a saucepan, put the lid down and come out. We all 'wander' all the time. It's only because we're watching all their behaviours. A lot of it is normal, just in an abnormal environment.*' (Participant 1.4).

4.3.2.4 The role of medication

In relation to restrictive intervention practice, mental health workers and practice leaders generally described medication as an approach of last (or at least late) resort. Mental health workers were clear that carefully prescribed, administered and monitored medication had its place in the care and treatment of people with dementia and it was felt that medication may be an appropriate form of restriction to apply in some circumstances, but expressed great caution when considering it.

'Sometimes you know, medication could have been used to see if that helps, but you're waiting on fifteen minutes, do you want to give somebody medication every time you just want to change them? And I think it's one of those where you really have to get to understand and weigh up all of those things, what is the right way to go about it to get the best outcome' (Participant 1.15)

A second mental health worker commented further on the timing of medication use:

*'I think you need to exhaust every other option, without exhausting her first and then going for that (*medication*) maybe'* (Participant 1.18)

A number of mental health workers explained that the reluctance to use medication, or to use it advisedly represented a change in their attitudes and practice over the last five to ten years. They described an increased awareness of evidence based prescribing guidance which has influenced dementia care and treatment.

'If the only way we can bring her down to some manageable level is medication...that might play a part but it's not something we would use first, not like we used to...these days, that really is a last resort because you have the risk of falls, further confusion. I think that's a general attitude, it's not just me. People will try and avoid it (medication) *if possible'* (Participant 1.6)

A practice leader (who was also a prescriber), confirmed their awareness of this general change in practice settings and also that their own practice and role has changed.

'I think previously, up until say 5 years ago, a lot of nurses didn't like to say the word anti-psychotic but when it actually came down to it, that's probably what they were asking for. I think now they're more likely to ask for

Memantine [a dementia medication which may reduce the symptoms associated with Alzheimer disease] *but they are probably slower to ask for drugs, full stop, to be honest'* (Participant 2.5)

4.3.2.5 The care environment

Participants described the environment and the impact on restrictive intervention practice. They explained that access to space and privacy was essential to least restriction. Mental health workers were recruited from two different mental health hospitals (sites one and two) where the physical environments differed. As described in chapter one, the first hospital hosted a dementia ward with 16 beds all of which were single en-suite bedrooms. The second hospital hosted a dementia ward with ten beds, eight of which were in four bedded single sex dormitories (Appendix 1). The internal ward environment for mental health workers working in an all single bedroom setting was not raised as an issue. When they discussed restrictive intervention practice and the need for access to appropriate space, this was always available via communal areas and individual bedrooms and bathrooms.

Mental health workers working in an environment with shared bedrooms raised two significant issues. Firstly, they described that the extent to which a person with dementia could be enabled to move freely around bedroom areas was to some extent dependent on the other service users and their needs. A mental health worker explained this issue as they were responding to a vignette (Appendix 9) whereby Mike is restless and walking around the ward.

'We'd say, so this is what Mike likes to do, this is what we're going to achieve so it would be that we would hope to allow Mike to have access all around the ward, notwithstanding encroaching upon other people's space...rooms. That's a bit different on our ward because we have got shared rooms'

(Participant 1.16)

Secondly, mental health workers described the difficulties of managing challenging behaviour which occurred within the shared bedroom areas. They explained that in order to reduce the impact on other service users, the threshold for intervening with a person with dementia may be lowered and the time taken to try other interventions (such as distraction) may be lessened. One mental health worker illustrated these issues when responding to another vignette scenario where a service user has been doubly incontinent during the night.

'…and it's also an issue because obviously we still have four bedded dormitories so it would depend whether the person was in a side room or in a dormitory, the speed with which they'd have to take action. If you're in a side room you've probably got a lot more time to talk and cajole somebody than you have in a dormitory, when you are going to, by default probably wake three different people up. So, the time that you have for these negotiations might differ depending on how she is reacting' (Participant 1.14)

In relation to the external environment, both hospitals had access to very similar outside space – both had a secure area which service users could access independently and both had a garden which was only accessed when service users

were escorted by a staff member or visitor. Participants from both hospitals described access to outside space as insufficient for the service users with dementia. This was in terms of the amount of space and the availability of ward staff to enable service users to use the space. They explained that service users could be restricted in terms of access to the outside and to physical exercise.

4.3.2.6 The importance of time

The issue of time and its importance when caring for people with dementia was raised by a number of mental health workers, for two different reasons. During two interviews, mental health workers raised the issue of insufficient time to deliver care but during other multiple interviews, mental health workers raised the use of time as a strategy to deliver care (taking time to build rapport, exploring alternative interventions) which reduced the need for restrictive interventions.

One mental health worker explored the notion of insufficient time to care and questioned whether this was a real or perceived issue:

> *'I think the factor that's always under pressure is time, that's the one thing I think people tend not to have enough of......or whether it's a perception, I don't know...there is always a perception of a lack of time'* (Participant 1.9)

This issue was described further by one of the practice leaders. They outlined broader explanations of inadequate training and funding, suggesting that ward based staff did not have sufficient time to complete all of the tasks required of them, and that they could not spend time building and maintaining therapeutic relationships with the service users.

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In response to vignettes and their own examples of real practice scenarios, mental health workers described using time as a strategy or intervention to engage the person with dementia. One mental health worker, responding to a vignette scenario of a service user with dementia who is declining to remove his clothing at night, explained how they would use time and repeated approaches to enable the acceptance of care.

'It just takes a lot of time..you show him the bathroom, you show him his clean clothes..and it just takes time and a lot of patience and when we have done all of that, and it hasn't worked..so then just give more time. It doesn't matter if he doesn't get into pyjamas all night.....Tomorrow is another day and we'll try again..it won't go on and on because once you've built up that trust...'
(Participant 1.4)

4.3.2.7 How training is structured

Practice leaders were considerably more explicit in terms of identifying sources of knowledge, acknowledging the importance of the content and statutory nature of restrictive intervention guidance and training. They also described the relationship between sources of knowledge and practice and identified the challenges of consciously linking theory to practice. They described the use of legislation and policy structure to inform the content of training which all mental health workers were required to undertake.

'It's a really interesting professional challenge....to learn to a standard that I am happy with about what the right and proper application of legislation is. I'm very mindful of my responsibilities within the Trust and how that plays into day to day professional practice issues for our nursing staff' (Participant 2.1).

4.3.3 Theme Three: Training and Supervision

The third theme brings together the findings which identified sources of knowledge that inform restrictive practice. Mental health workers discussed the importance of restrictive intervention training and supervision (the latter was described less frequently and not noted as important except when it followed a significant restraint incident).

4.3.3.1 The restrictive intervention strategies used by staff

As described in chapter one, physical intervention training was mandatory for all staff in practice (for Site one, Positive Behaviour Management or Prevention (PBM) and for site two, Positive Management of Violence and Aggression (PMVA).

This training (both models), commissioned by the host Trust was repeatedly described by mental health workers as being framed by a least restrictive approach. They described an expectation that staff would find solutions to the management, care, treatment of people with dementia which did not require a 'hands on' approach – resolving conflict whenever possible and safe. This was supported by practice leaders who explained that practice must be governed by various bodies of knowledge (legislation, case law, policy) which mental health workers cannot always articulate. Mental health workers and practice leaders described physical intervention as a strategy which was employed when 'all else

failed' but that the techniques of conflict resolution were reported to be central to practice with people with dementia.

> *'In physical behaviour management, we tend to think in terms of restraint and sort of gentle support and guiding away when someone's becoming a bit physically aggressive but actually there's a huge part to play in, way before you get to that stage in talking to somebody and finding out why they're aroused and why they're distressed and yes, in the sense everybody can see why they are...... if they are on a ward and want to go home, there are ways of looking at responsive strategies'* (Participant 1.2)

> *' I would expect that staff would know where to intervene through a combination of their training, their induction in the Trust, the care plans that the more senior staff have provided for the care assistants. A lead should come from the ward manager, from the consultant and the more senior clinical people on the ward......staff do need that guidance, they need to be able to use .....their personal judgement but I think those ideas need to have some senior back up'* (Participant 2.3)

Mental health workers repeatedly reported that they are trained to assess all service users as individuals and to find individual least restrictive solutions which may change over time.

> *'It's very rare that we use PBM* [positive behaviour management] *to be honest, it's much better to use your skills.....I think PBM is a bit of a failure in your nursing skills really...'* (Participant 1.6)

4.3.3.2 Different roles

Mental health workers on the ground described increasing their knowledge and knowledge sources over time (learning from peers, reflecting practice, supervision, formal training). Mental health workers with more years of experience described a different and detailed understanding of that which framed their practice. Mental health workers also described learning from their colleagues. A practice leader described how they were also aware of this learning between staff:

> *'Not everyone can be trained in everything to the same degree and I think it's about maybe all disciplines accepting and respecting the value of other people's knowledge and skills'* (Participant 2.2)

Staff also described practice as shifting and developing. Participants (both mental health workers and practice leaders) described the challenge of this - to keep pace with new knowledge and best practice. A practice leader described the complexity of new knowledge in relation to legislation and emerging case law impacting on an already complex clinical workplace:

> *'I love mental health nursing. I think it's one of the most fascinating subjects you could get into....I was always learning something new, it never stays the same. When the Mental Capacity Act and Deprivation of Liberty Safeguards were being introduced, I was really interested in it because essentially......it scared me because I thought 'I don't know if I really understand this'......I constantly relate everything to a nurse being*

able to deliver the care in line with legislation and best practice at 3 o'clock in the morning after their fourth night shift in a row.

Is this something that somebody can easily deliver and understand?' (Participant 2.1).

4.3.3.3 Reflection and supervision

Reflection and supervision as intentional processes did not feature strongly in the content of interviews. Opportunities to consider or reflect on practice generally or specific examples of restrictive interventions were not frequently described. Mental health workers reported that formal supervision in relation to restrictive intervention management was available if asked for but not mandated or routinely provided. Mental health workers explained that supervision, framed as a de-brief session would be offered if a significant restraint incident had occurred. Mental health workers reported that the ward handover was a source of regular support and information in relation to managing challenging behaviour.

'Give a heads up about behaviour ......if you have used PBM, they must have been quite distressed' (Participant 1.18)

One mental health worker described supervision (described as debriefing) to be an important aspect of ward based practice but this was not a feature of most mental health worker interviews.

"I understand the importance of being able to have a quick de-brief.....it can be frightening so it's important to have a de-brief'

'I think it's actually really important and sometimes we have newly 'qualifieds' (registered nurses) .....and I'm always very aware for them...and it is traumatic to see somebody really distressed' (Participant 1.12).

4.3.3.4 Emotion and the caring role

Mental health workers also talked about the emotional effort of caring and specifically the impact of working with people with challenging behaviour who exhibit distressed behaviour. They described some positives of working with people with dementia. They talked about feelings of satisfaction and self-worth associated with their roles as mental health care staff. Conversely, some mental health workers described the experience of being subjected to aggression at work. They explained that they understood the relationship between aggression and dementia but that it can be difficult to endure. A practice leader described the challenges faced by front line staff:

'If you are a carer at work...the bit you don't particularly like is being sworn at or clobbered, I think people can put up with most things, I think they are quite happy to clear up faeces and urine .....the bits they don't like are when there are threats to themselves and some of that is just common sense- because it will hurt....I think that for caring people, it's harder to deal with' (Participant 2.4).

4.3.4 Theme Four: Person-centred care and restrictive interventions

The title of the fourth theme describes the importance of person-centred practice to both mental health workers and practice leaders. Mental health workers described a

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strong alignment to person-centred care principles, regardless of the characteristics of the person with dementia. The vignettes enabled exploration of age and gender but participants repeatedly stated that every person is an individual and should be assessed as such. Central to this theme was what participants described as the importance of getting to know the person with dementia and using this knowledge to enable least restrictive practice. The sub themes below were all linked to the concept of knowing the person.

4.3.4.1 Each person is an individual

The mental health workers were aware that each person with dementia has characteristics or attributes (gender, age, physical size). These attributes were described as important in terms of understanding the person to inform assessment, care planning and the need for restrictive interventions. The mental health workers also explained that every person is an individual and that there were 'no rules' in terms of attributes.

> *'…there is never a general rule..every single person is completely different'* (Participant 1.17)

> *'…it's not gender related, it's not age related.....it's around their care needs....personalised care'* (Participant 1.3)

In relation to restrictive intervention practice, physical attributes were described by mental health workers as most relevant (regardless of age or gender). The mental health workers explained this by recalling a physically robust 90-year-old farmer or retired sportsmen and women and frail 60 year olds who have long term physical health conditions. Some mental health workers also described the 'matching' of physical attributes between service users and staff to reduce the need for restrictive

interventions – when a service user is exhibiting behaviour which may challenge care delivery, staff who are physically similar to a service user are more likely to be able to positively engage reducing the risk of intimidation or vulnerability. Practice leaders also made reference to the importance of 'physical matching' in relation to restrictive intervention care planning, confirming the discussion of this approach in staff training programmes. Some other participants suggested contrasting colloquial views about physical matching and there were no recognised tools or practice guidance to support a particular view.

Practice leaders discussed gender as an attribute in broader terms. They were aware of gender issues in terms of people with dementia and staffing teams – both with a majority of women. They described the impact on care delivery in terms of a limited number of male care givers and ward environments.

> *'I think that in essence it* (gender) *is a very powerful thing....I think that we have become much more sophisticated and aware of those issues'* (Participant 2.1)

4.3.4.2 Communication and uniforms

In both settings, ward based mental health workers wear uniform, while practice leaders do not – in this study, mental health workers repeatedly described the wearing of uniforms as helpful. On a practical level, uniforms were described as improving staff well-being because they addressed the infection control agenda, gave staff a sense of positive identity and were comfortable to wear. In terms of communication, uniforms were described as a positive influence – participants explained that they enabled service users to recognise staff as care givers, people who are intending to help. No participants were unsupportive of uniforms.

A number of mental health workers supported uniforms:

'I think it's good....when we had no uniforms and we had people with dementia they didn't recognise where they were...so I think in that sense it helps them identify where they are' (Participant 1.10)

'…they can identify that we are nurses and healthcare assistants and we are here to help. I like a uniform. It's clean, it's tidy and people know who you are' (Participant 1.18)

'…so I think in terms of the effect of a uniform...I think the older generation do like to see a uniform...something that's perhaps a bit more grounded..so I do think they do respond well'.
(Participant 1.13)

4.3.4.3 Getting to know the person

Mental health workers described person-centred approaches to restrictive intervention practice which were used to deliver care in both ward environments. They described being determined to understand the thoughts, feelings and behaviour of people with dementia to enable them to respond positively. They acknowledged the importance of knowing the person with dementia and described their role as understanding the person rather than managing the behaviour which challenged. One mental health worker who was talking about their observations on joining a ward team explained.

'One of the things that I've been really impressed about here is that it's not about staff saying 'Oh they're not communicating' or 'They can't tell us what they need'. It's about 'We didn't understand' …….we need to think what they are trying to say to us: it's not their problem, it's ours' (Participant 1.1)

Mental health workers talked about the relationship between knowledge about a person with dementia and the need for restrictive interventions. They explained that if the person is known well to staff, that knowledge can be used to understand behaviour, reassure and de-escalate situations.

A mental health worker discussed one of the vignette characters (Mike: Appendix 9) and explained how the knowledge of Mike's lifestyle and understanding the importance of his dogs would have enabled the care team to use strategies which are least restrictive. They said:

> *'I would talk about the dogs, I would talk about Sarah (his wife).. ..I would talk about something familiar that would calm him…something that he can immediately think 'Ah yes, I know where you are now' ..you are taking away from the immediacy and the discomfort'*
>
> (Participant 1.12)

This approach was reinforced by other mental health workers who also described the importance of knowing the person with dementia – being able to connect with them as people (names, family structures, routines, work histories, interests). One mental health worker described the importance of connecting with a person in terms of improving the well-being of people with dementia (engaging and communicating to minimise the need for restrictions) and also of the staff when they are able to see that they have made a positive difference:

> *'You think – we've done something today. You know, you just make them smile. Sounds like nothing, but it's huge'. (*Participant 1.4)

4.3.4.4 Care planning for person-centred care

For mental health workers, the theme of least restrictive person-centred care was articulated in many interviews. As with earlier themes and sub themes, knowing the person with dementia was described as essential to enable effective care planning. Person-centred care was described or referenced when discussing approaches to restrictive interventions, often as a broad term to describe how or why they are used (or not). This least restrictive approach was acknowledged by practice leaders as they discussed the vignettes within the semi structured interviews. The leaders described direct person-centred care delivery as challenging because it seeks to understand the experience of the person with dementia in terms of care planning and the potential need for restrictive interventions.

> *'I think that one of the big responsibilities of the team...is to try to understand what's going through this guy's mind, what his concerns are..and that's not easy...but I think that's important'* (Participant 2.4)

In terms of care planning and risk assessment, getting to know each person was described as important as that knowledge informed the risk assessment and therefore the care plan and risk management. Mental health workers explained that they do not rely on assumptions – for instance that being older or female means that a person is less strong, because it may not be the case.

> *'Just because she is now in their 80's doesn't necessarily mean....they might not be a pussycat....you have to be aware of each person being different'*
>
> (Participant 1.2)

The vignette based discussions contained an emphasis in care planning based on strengths: the mental health workers asked what can this person with dementia do to support themselves. This strengths based assessment and care planning also included a need to ensure safe practice. For instance, mental health workers encouraged positive assessment in relation to physicality:

> *'I think it is a misnomer to call it challenging behaviour....there is a definite correlation between someone's physical fitness and their drive and their physical motivation'*
>
> (Participant 1.9)

Practice leaders expressed broader and more complex views in relation to person-centred approaches and how they impact on assessment and restrictive intervention practice. They described the importance of a multi-disciplinary approach to assessment as they believed that the assessment identifies risk and impacts on the restrictive interventions which may be applied. Practice leaders also discussed the relationship between risk and restrictive interventions in the context of legal frameworks. They described that over recent years, the ward staff have developed a good understanding of their role in ensuring least restrictive practice:

> *'I think that the staff on the wards have an inherent wish to make lives better and I think that 15 years ago that was expressed in terms of giving good personal care...and now I think there is more understanding about freedom'* (Participant 2.2)

Another care planning approach was described by mental health workers as the 'This is Me' booklet (published by the Alzheimers Society and used on each of the wards). This is a paper based document which helps the person with dementia and their family to tell staff about themselves, their preferences and interest. These profiling tools were described as informing restrictive intervention practice as they portray individuals at their 'baseline', helping staff to understand what usual behaviour looks like for the person with dementia.

> *'We've got the 'This is Me' paperwork and the personal profile ...and the behaviour support plans that look at people at their baselines...and that gives you a really basic, quick 'these are the things I do when I am well'* (Participant 1.1)

4.4 Conclusion

I found that mental health workers on the 'front line' of practice described their interventions in a person-centred way – linked to direct restrictive intervention training. This finding related to mental health workers from both units within the study, despite each unit having a different restrictive intervention training approach and differences in the physical environments of the wards. From both units, mental health

workers reported that the mandatory training delivered a focus on conflict resolution via person-centred approaches – avoiding the need to for restrictive interventions.

Mental health workers who were closest to practice demonstrated a descriptive understanding while the distance from practice of the practice leaders enabled a broader perspective. Mental health workers did not often describe their practice in the context of law and policy while practice leaders advised that the shifting influences of policy, case law and legislation are 'distant' to the reality of practice. Within this chapter, I have written about translation processes at three levels. Firstly, practice leaders described a process of understanding legislation and case law to inform organisational policy and procedures. Secondly, practice leaders described how they influence and update training programmes. Finally, mental health workers explained how they translated the knowledge and skills acquired through restrictive intervention training into practice which enabled them to utilise person-centred approaches to restrictive interventions for people with dementia. Participants also described learning form one another and mental health workers described learning from people with dementia as they delivered person centred care and treatment. The knowledge journey or the process of knowledge transfer is not therefore linear or one directional.

The discussion chapter will consider these findings and their meaning further. It will seek to understand how 'knowing' about restrictive intervention practice differed for practice leaders and mental health workers and how ways of knowing were enabled by translation - as knowledge which emanated from legislation translated to inform the restrictive intervention practice received by people with dementia and vice versa. The chapter will explore the complex and multi directional pathways which knowledge may take.

Chapter Five: Discussion

5.1 Introduction

This chapter essentially completes the process of analysis as described by Braun and Clarke (2006) who describe a sixth stage of analysis which brings together and reports on findings, providing context and suggested explanation.   The chapter provides a discussion of the study findings which were described in the previous chapter: legislation and practice, the structures provided by the NHS Trust, training and supervision and person-centred care and restrictive interventions.

Alongside this alignment to Braun and Clarke's (2006) process, the content of this discussion chapter has also been influenced by my own research journey, from the initial ideas which informed the research question to understanding the complexities of data analysis and associated findings described in the previous chapter.   This journey has been enabled by reflective discussions with academic and practice colleagues and ongoing engagement with the literature.   Key reflections have related to gender and intersectionality (in this research and the importance to wider debate about dementia), the use of vignettes as an interview framework and the complexity of learning patterns which have emerged .

This chapter also provides a framework for the findings - a 'Model of Translated Ways of Knowing' (Figure 5.1). I have developed this new model in response to the findings of this research. It is discussed with reference to the background chapter, the literature review chapter and wider contemporary literature related to restrictive intervention practice and theoretical ways of knowing. The model will be explicitly linked to the key findings in order to structure a discussion which refers to existing practice and considers implications for practice and research in the future.
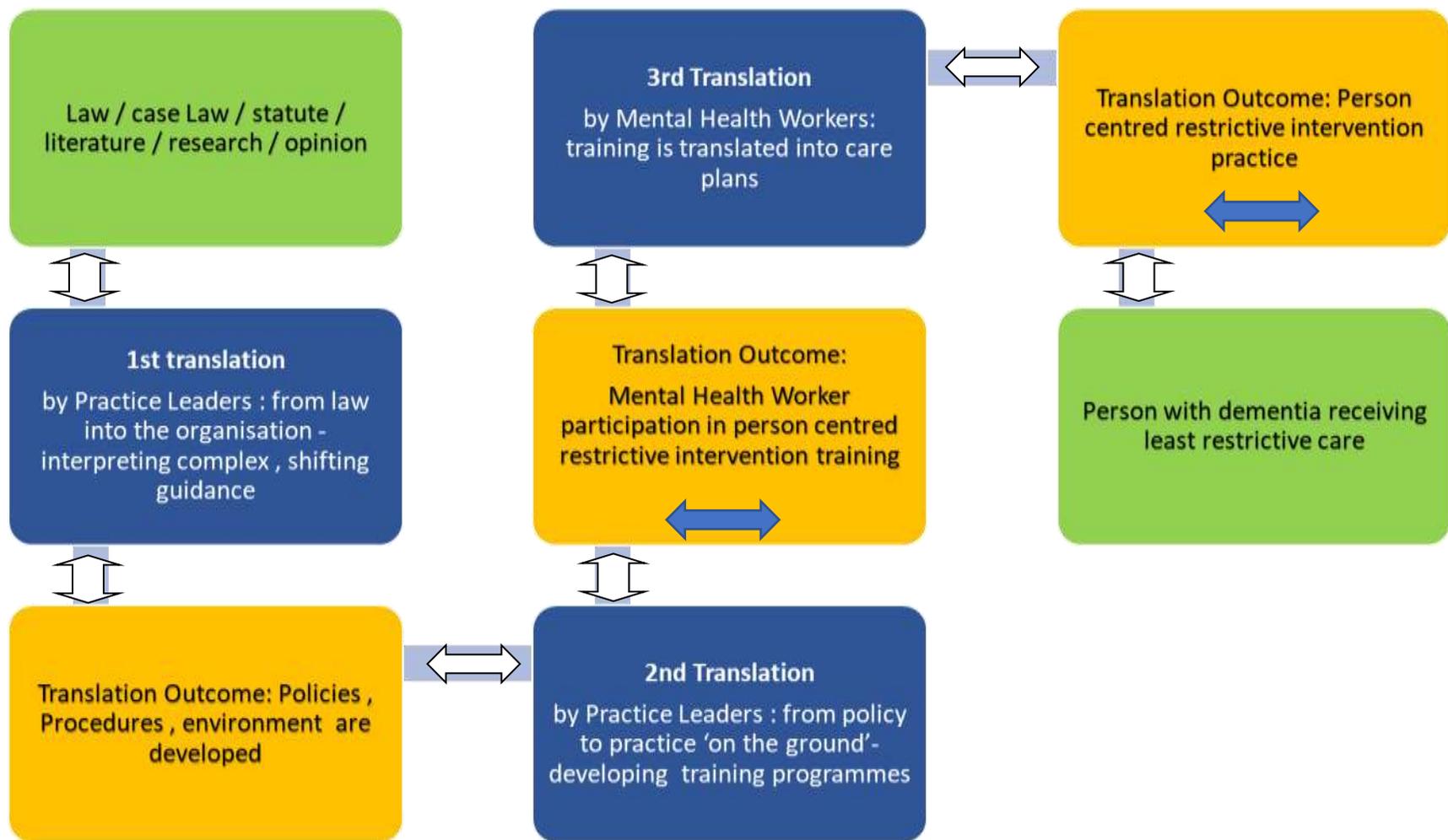
Figure 5.1:

The Model of Translated Ways of Knowing

Knowledge moves in both <u>vertical</u> directions: between practice leaders, mental health workers and people with dementia and <u>horizontally</u> between mental health workers.

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5.2 'Model of Translated Ways of Knowing'

As described above, the findings of this study suggest that practice leaders and mental health workers come to know and use information differently:

- Practice leaders actively pursue knowledge via theoretical and practice supervision routes

Practice leaders actively engage in the understanding of case law developments and are aware of new evidence as it is published. They have lead roles in developing and reviewing policies which frame practice and they are responsible for developing and delivering evidence based restrictive intervention training via the supervision of mental health workers and their own specialist practice.

- Mental health workers actively participate in practice based learning

Mental health workers complete mandatory restrictive intervention training – the content of which they translate into person-centred least restrictive practice.

Figure 5.1 illustrates how knowledge progresses between legislation and practice and that a successful 'knowledge journey' is dependent on translation, outcomes and is complex and multi directional.

I identified three phases of translation of multi-directional knowledge and three outcomes in this process:

1. Statutory law, case law, research and literature are translated by practice leaders which then 'enter' the organisation via policy development and review.

   - Outcomes:

     i. Policies and procedures are developed and environments are adapted.

     ii. Practice leaders will listen to feedback from mental health workers which will influence policy development and may feedback into national debate.

2. Policies are translated by practice leaders and weaved into restrictive intervention via training materials and curriculums.

   - Outcomes:

     i. Mental health workers are able to access restrictive intervention training informed by current statutory law, case law, research and literature in an accessible format.

     ii. Practice leaders will listen to feedback from mental health workers which will influence training development

     iii. Mental health workers will learn from one another during training – this may be conscious or tacit

3. Mental health workers receive restrictive intervention training and translate approaches into practice delivery via care planning.

   - Outcomes:

     i. Mental health workers are able to deliver person-centred restrictive interventions because they are equipped with the relevant skills based knowledge.

ii. Mental health workers will learn from one another in practice – this may be conscious or tacit

iii. Mental health workers may receive verbal and non-verbal feedback from people with dementia receiving care.

The model suggests that in a modern, mental healthcare environment which offers specialist care and treatment for people with dementia, it is not possible for frontline mental health workers to be able to articulate the shifting and complex nature of case law and emerging evidence and opinion. The model (Translated Ways of Knowing) further suggests that it is an organisational responsibility to provide translation in the form of practice leadership which will structure policies and training content to inform direct practice.

5.3 Ways of Knowing

As discussed, the 'Model of Translated Ways of Knowing' suggests that practice leaders come to know information in a different way to mental health workers (Reason, 2006). In considering these differences between mental health workers and practice leaders in relation to how they understood and interpreted theory and knowledge that informed restrictive intervention practice, it is helpful to consider structural and theoretical explanations of 'ways of knowing'. There are a number of seminal ways of knowing theories, two of which are rooted in professional practice (originally specific to nursing). In 1978, Barbara Carper described four patterns of knowing which moved away from the rigid learning characteristics of the medical model and towards a flexible, imaginative approach to learning. The identification of different patterns of knowing provided a tool to understand and therefore support different ways of learning (Zander, 2007). Soon after, Patricia Benner (Benner, 1984)

developed her theory of Novice to Expert. This theory described learning as being developed over time and also asserted that individuals could know how to do something without learning or understanding the theory behind it (referred to as 'knowing how' without knowing that').

More recently, Heron & Reason (2008) offer an extended epistemology which seeks to explain 'how we know' and describes four ways of knowing that are used unconsciously in everyday life. They suggest that there is an interchange between the ways of knowing to adapt to different circumstance and roles, often without an awareness of them. Table 5.1 below sets out the four ways of knowing and offers a brief explanation of each.

Table 5.1: Heron & Reason (2008) four ways of knowing:

Way of knowing	Explanation
Propositional knowing	Intellectual knowing of ideas and theories
Presentational knowing	Knowing which is generated from experiential encounters
Practical knowing	Knowing how to do something. Skills, competencies
Experiential knowing	Direct face to face encounters

This 'four ways' model goes beyond conventional ideas of how knowledge is acquired – it suggests that the relationship between oneself and knowledge can also be about participation and intuition. In relation to this model (the findings of my study suggest that frontline mental health workers are largely experiential and practical in terms of how they acquire new knowledge) while practice leaders utilise propositional and presentational knowing. Table 5.2 below sets out the four ways of knowing and links them to the findings of this research.

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Table 5.2: Application of the model to this research

Way of knowing	Application to this study
Propositional knowing	Practice leaders <u>and</u> some mental health workers engaged with academic theory (case law, statute, literature, research findings)
Presentational knowing	Practice leaders facilitated learning for mental health workers via reflection (supervision, peer discussion, ward handovers, incident debriefings)
Practical knowing	Practice leaders in clinical practice and via supervision <u>and</u> mental health workers rehearsed restrictive intervention practice in training scenarios and in practice.
Experiential knowing	Practice leaders in clinical practice <u>and</u> mental health workers learned from repeated direct practice experience (or exposure to the practice of others via observation and description and discussion).

5.3.1 Propositional knowing

As outlined in the tables above, propositional knowing relates to an intellectual way of understanding new knowledge. In relation to this study, the practice leaders (and some mental health workers) were able to discuss and debate the complexities of case law, legislation and codes of practice which impacted on restrictive intervention practice. They were able to analyse and synthesise this knowledge while understanding that it is shifting and subject to change – they described an expectation of change and their responsibility to respond and adapt to that change. They also described their role as informing Trust policy, procedures and training – translating the propositional knowing to enable clinical practice.

5.3.2 Presentational knowing

This mode of knowing refers to learning which is generated by experience. In relation to study findings, this linked to the issues of training and supervision. Practice Leaders were consciously reflective about their roles and the context in which restrictive practice existed - there was an overt recognition of complexity and the unrealistic knowledge expectations placed on mental health workers. Practice leaders were aware of and sought to facilitate reflective practice via supervision and clinical debriefings after restrictive practice incidents and during ward handover periods. Mental health workers were clear that their practice was closely informed by restrictive intervention training but less clear about the role and relevance of supervision – it did not feature strongly in their discussion groups.

5.3.3 Practical knowing

Practical knowing relates to skills, competencies and 'doing' and in relation to this research is relevant to frontline mental health workers who learned via training and from one another in restrictive intervention practice scenarios and subsequent discussions. The restrictive intervention training which was received by frontline staff was largely skills based, asking mental health workers to repeatedly practice verbal and physical restrictive intervention techniques with a focus on conflict resolution and the avoidance of restriction. Mental health workers described the training in positive terms, suggesting that this was an important source of knowledge in relation to restrictive intervention practice. In terms of academic knowledge hierarchies, practical knowing is often not held in the same high esteem as theory but it may be argued that it is the enactment of knowing – absorbing presentational and propositional knowing and translating into practice (Heron & Reason, 2008).

5.3.4 Experiential knowing

Experiential knowing, or learning from repeated experience, is significant to frontline mental health workers because of their daily practice based contact with service users and other mental health workers. Experiential knowing can also be linked to the concept of tacit knowledge (a body of understanding held by a person which they may not be consciously aware of or able to explain) (Boden, 1990; Chea & Abidi, 2001; Fodor, 1981Polanyi,1958; Turing, 1950; Vincent & Wallace, 2015).

The concept of tacit knowledge is often first attributed to Polyani (1958) who wrote about the importance of embodied knowledge which was not seen as having the credibility of conventional knowledge – it was seen as having negligible epistemic worth. To understand this stance, it is helpful to consider the meaning of epistemology or 'the nature of knowledge' – traditional understanding of epistemology regards knowledge as rooted in rational beliefs and truth (Berragan,1998; Carlsson et al. 2000; Heron & Reason, 2008; Ting et al. 2011).

To trust in the existence and validity of tacit knowledge is to accept that it can be transferred without it being written down or formally described – this concept challenges the traditional view and has been discounted by some academic communities (Foster, 2016). To consider the value and risks of tacit knowledge in relation to restrictive intervention practice, it is helpful to draw a comparison with a simple physical task such as tying a shoelace. If you take the shoelace task apart by slowing it down, the person's ability is diminished – it is easier to execute the complete shoelace task as tacit (the steps of the task are known without close examination).

However, if a process or task is tacit, the rules and the person's performance are not available to a person for conscious examination – hence there is less control and an inability to reflect on the experience (if the shoelace is not tied securely, the reason why is not known). Herbig et al. (2001) suggested that where practice knowledge was acquired implicitly or tacitly, the knowledge and associated skills were not subject to reflection and critical review as they could not be effectively articulated. This stance was supported by Kinsella (2009) who described tacit knowledge as lacking conceptual clarity and emphasised the importance of reflection to enable practice scrutiny. Welsh and Lyons (2001) and Thornton (2006) were accepting of the existence and importance of tacit knowledge and suggested that traditional learning and supervisory approaches can be used to validate tacitly held learning.

In relation to this research, supervision and reflection were not identified by most mental health workers as key support mechanisms but they described training and peer support as central to everyday practice. Mental health workers did not often consciously examine the way they gained or passed on knowledge about restrictive intervention practice. Practice leaders described the importance of regular supervision and incident debriefing to practice for mental health workers– they acknowledged the challenges of enabling reflective opportunities in busy ward environments and sought to work alongside mental health workers to enable 'live supervision and reflection' – this approach may then enable articulation of tacit understanding to allow scrutiny and debate. The Model of Translated Ways of knowing illustrates that 'horizontal' transfer of knowledge which may be conscious or tacit, when staff work alongside one another.

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5.4 Levels of Translation

As illustrated in Figure 5.1, I identified that translation of knowledge took place at three points. The key findings can be set against these points of translation and their associated outcomes to articulate the relevance of the 'Model of Translated Ways of Knowing'.

5.5 Level 1 Translation - From Law into the Organisation

At the first point of translation, the practice leaders were actively engaged with statutory law, emerging case law, national policy guidance, literature and research findings. They were interpreting a complex and shifting body of guidance to enable the development of Trust policies, processes and environmental guidance.

5.5.1 Legislation

The core of this first level of translation related to the complex legislation which frames restrictive intervention practice. The study found that legislation, specifically the Mental Health Act (2007), Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (2007) were central to and well understood by practice leaders.

It was felt by practice leaders to be an unrealistic expectation that frontline staff should be able to articulate the intricacies of statute law and case law (sometimes referred to as 'judge based' law) which is ever changing and evolving. Practice leaders sought to understand the complex and shifting nature of legislation and ensure that least restrictive principles and approaches had been effectively

communicated to frontline staff via Trust policies, processes and restrictive intervention training.

Literature relating to clinical leadership posts suggest that there is little research to date in terms of the intention and impact of practice leader roles (Kennedy et al, 2012). This is particularly true for roles in mental health settings where evidence is largely limited to Consultant Nurse posts. A review in 2007 concluded that the evidence was limited in terms of methodological quality and the impact on service users was mostly unknown (National Nursing Research Unit, 2007). Clinical leadership roles are broadly described in terms of research, education, practice influence and empowerment rather than in terms of translation of complex knowledge or concepts (Donaldson-Feilder & Lewis, 2016).

5.5.2 Level 1 Translation: outcomes

As Figure 5.1 illustrates, each level of translation is linked to a set of outcomes. Level 1 translation from law into the organisation led to policies, procedures and physical environments being developed or influenced by practice leaders.

5.5.3 Medication and policy

Mental health workers were clear that medication was a form of restriction which should be used in a limited way, often as a last resort when other approaches had been exhausted. The Trust had a comprehensive 'Policy on Prescribing and Administration of Medicines' which ensured that systems were in place to manage all medicines including those which may be defined as restrictive in terms of their impact on a service user. Mental health workers discussed behavioural and psychological symptoms in people with dementia (which may include restlessness, agitation,

aggression, hallucinations, delusions) in the context of the vignettes constructed for the research and in examples of practice which they introduced during the interviews.

Mental health workers discussed the importance of understanding the experience of the person with dementia when seeking to identify the cause of any distress and addressing those issues – therefore negating the need to consider medication (this is illustrated in Figure 5.1 in that knowledge passes between people with dementia and mental health workers). The mental health workers described access to policy guidance and Trust based restrictive intervention training as being central to approaches to using medication.

5.5.4 The management of risk policy

The management of risk was a significant issue for mental health workers in relation to restrictive intervention practice. They described repeated and detailed assessments of people with dementia to gauge their risks in relation to a number of areas: falling, harm to self, harm to others and self-neglect (particularly in relation to skin integrity and the risk of pressure ulcers).

The literature suggests that risk assessment in mental health settings is a valuable but vulnerable process (Undrill, 2007) as mental health workers are often making decisions based on limited information and in uncertain circumstances. Additionally, the issue of secondary risk management (managing the anxiety of the clinician who fears the consequences of a wrong decision for themselves) is key. For example, when mental health workers assess the risk of intervening or not intervening to enable least restriction while protecting skin integrity in a service user who has been incontinent, they will be concerned about the risk to the service user (the primary risk) and the risk to their own reputation and liability (secondary risk) (Power, 2004).

Practice leaders were empowered by the Trust to influence policies which enabled mental health workers to engage in positive risk taking and adopt least restrictive approaches. The mental health workers viewed the policy structure as supportive to service users, providing a legal and professional 'protective cloak' for themselves as clinicians. The literature suggests that this is a valid function for those in clinical leadership roles as they are able to link practice to an understanding of underpinning theory (Griffiths, et al. 2013; Humphreys et al, 2007; Michalec et al. 2017; Spencer & McLaren, 2016).

5.5.5 The environment

Mental health workers described two environmental issues which they believed impacted on restrictive intervention practice: shared bedrooms and staff uniforms:

5.5.6 Shared bedrooms

Mental health workers working observed that when dealing with behavioural and psychological symptoms of dementia in a shared bedroom, the threshold for restrictive interventions may be lower to minimise disruption to other service users. They explained that in the privacy of a single bedroom, it is possible to explore a number of strategies (distraction, reminiscence, music, talking) without disrupting sleep and causing distress or harm to other service users. In a shared bedroom, behavioural and psychological symptoms may cause distress to others and staff may consider utilising restrictive interventions to minimise disruption (eg via the use of medication) or to assist the person to leave the shared space. The literature and evidence base to date is limited in terms of the impact of shared versus single

bedrooms (Day et al. 2000; Zeisel, 2000). Later research (Dobrohotoff & Llewellyn-Jones, 2011) does however acknowledge and advocate for the provision of single bedrooms for people with dementia.

5.5.7 Uniforms

Practice leaders did not wear uniform but mental health workers at both hospitals did. Mental health workers supported uniforms in practice and related the advantages to communication and infection control – they did not link uniforms directly to restrictive intervention practice. The literature and empirical evidence in relation to uniforms is limited, inconclusive and does not address the role that uniforms may play in restrictive intervention practice and offers mixed views about their value (Bates, 2012; Cleary & Doody, 2017; Kucuk et al. 2015; Pearson et al. 2001). In this study, the positive benefits of uniforms were described by a number of mental health workers in terms of minimising the need for restrictive interventions. They thought that the uniforms enabled people with dementia to identify them as carers (people trying to help rather than harm) and that as mental health workers, they therefore encountered less fear, distress or resistance when they sought to offer care and assistance.

5.6 Level 2 Translation – from Policy to Practice

At the second point of translation, the practice leaders were continuing to address the theory and practice gap, developing training programmes which emphasised conflict resolution and least restrictive approaches and absorbing feedback from mental health workers. This function could also be likened to that of an expert facilitator in the context of implementing evidence based practice. Harvey and Kitson (2016), in their review of the Promoting Action on Research Implementation in Health Services (PARIHS) identified that there is growing evidence that key staff play significant roles

in the implementation process. They suggest that organisations committed to innovation must reflect knowledge translation roles in their leadership structures.

5.6.1 Level 2 Translation: translation outcomes

The outcome of this second level of translation was that all mental health workers were mandated to participate in restrictive intervention training which offered theory and practical tuition for approaches which were specific or tailored to people with dementia. During training, mental health workers were able to learn from one another.

5.6.2 Training and supervision as translation: informing restrictive intervention practice

This research suggests that practice leaders were acting as gatekeepers to positive working conditions for mental health workers. They facilitated access to training, supervision and reflective opportunities which in turn enabled mental health workers to manage greater levels of challenge in practice. This link between practice leadership and the enabling of positive working environments is supported by Donaldson-Feilder & Lewis (2016), who found that leadership which positively enables the work environment also supports the mental health of staff, particularly those working in challenging environments.

Mental health workers described acting in practice as they are trained to do in that they sought to resolve conflict before considering restrictive interventions. This finding is partially in keeping with the thematic analysis of literature in Chapter two which found that staff education and supervision reduced levels of restrictive intervention

use. In my study, however, mental health workers were aware of supervision as a practice tool but did not routinely utilise opportunities for reflection and supervision, unless a significant incident had occurred. When mental health workers and practice leaders did discuss supervision, it was in relation to staff support and well-being rather than reducing the level of restrictive intervention practice.

5.7 Level 3 Translation – the delivery of person-centred restrictive intervention practice

At the third point of translation, the mental health workers translated knowledge and skills acquired via the restrictive intervention training programmes into person-centred care plans for the people with dementia who were service users on the ward, seeking feedback form people with dementia in terms of attempting to understand their needs and wishes.

5.7.1 Level 3 Translation: translation outcomes

The outcomes of this level of translation was an approach to restrictive intervention practice which was person-centred, seeking to resolve conflict and avoid restriction where possible.

5.7.2 Person-centred restriction

For mental health workers, a person-centred care approach was the most overt influence in relation to restrictive intervention practice. For mental health workers, the precedent of treating every person as an individual seemed to be 'part of the fabric' of both units where the research took place. It was repeatedly presented as 'the way

we do things round here' despite the challenges of the practice environment (limited time to care, some shared bedroom environments).

The person-centred care approaches which were described were in keeping with the original work of Kitwood (1997), aiming to understand the experience of the person with dementia and the social psychology which surrounds them (the environment, relationships, opportunities to engage and be occupied). They were also aligned to more recent person-centred care planning guidance (Dewing, 2008; May et al. 2009) in that people with dementia should be as self-directed and as in control of their care as possible, to achieve best outcomes.

5.8 Gender and intersectionality

As I described in chapter 3, I sought to move beyond the issue of gender and dementia to utilise intersectionality as an explanatory structure for this study. This approach aimed to facilitate an understanding of people in the context of social status or location. My findings however, challenged the importance of the concept as participants described their experiences and understanding of dementia very differently.

The mental health workers discussed the person-centred approach at a descriptive level, acknowledging the uniqueness of individuals and the need for equality of care provision, regardless of individual characteristics or cognitive disability. They did not discuss the experience for individuals within their wider social context and did not describe groups of people as being more vulnerable than others: intersectionality would go further than this understanding of people as individuals and encourage a

view that there is no simple experience of an individual identity – each individual is contextualised (Walby et al. 2012).

In this study, for mental health workers, understanding of an individual was described as central to care. This involved an in-depth assessment process sometimes referred to as personality profiling (May et al, 2009). This approach enabled personhood as described by Kitwood (1997) and more recently by Mitchell & Agnelli (2015) in that the staff were bestowing the status of an individual upon the person with dementia. The person was recognised and respected as a unique human being and their sense of wellbeing was enhanced.

Gender may be considered as a simpler, single 'human category' in relation to intersectionality but mental health workers did not consider gender to be a perspective which impacted on care and treatment. They did not see dementia as a particular issue for women (though they did acknowledge that the majority of staff and service users were women). The literature and demographic evidence details that women are disproportionally affected by dementia both in terms of numbers and power across the world. Women make up the majority of dementia staff groups (but leaders are often male) and disproportionate numbers of women are informal carers or have dementia themselves (Ludwin & Parker, 2015).

In the literature review (Chapter two) I identified a theme related to gender, dementia and restraint. Gender was described as a characteristic of participant groups in the studies included in the literature review (a majority of staff participants and service user participants were women). Only one study described the issue of gender (Gerace et al. 2013), but no study offered further exploration or analysis. Similarly, in my study, the interview vignettes invited discussion of gender and mental health

workers were aware that the majority of service users, informal and formal carers were women. Despite this opportunity, participants did not identify gender as a particular issue for people with dementia although some did relate it to themselves as mental health care staff. The male mental health workers were aware of gender in relation to male staff delivering care to female service users – in terms of secondary risk management (Undrill, 2007). They described caution in terms of delivering care to a female service user – they routinely offered a female carer to female service users and used a second carer as a chaperone if a male nurse was delivering treatment to a female service user. Enriched care planning approaches would suggest that this approach may not be helpful to people with dementia (Kitwood, 1997; May et al. 2009) – the person may respond negatively to a nervous or cautious male carer or may feel threatened by the presence of a second carer. This may increase behaviour that is challenging to staff and therefore the need for restrictive interventions. The enriched approach encourages mental health workers to consider the profile of a person (life history, lifestyle, personality, capacity for doing, cognitive support needs and health) and it does acknowledge that certain characteristics (eg gender) will shape a person's experience of dementia (Westwood 2016).

In this study, mental health workers believed that understanding the characteristics of an individual and sometimes the sum of those characteristics (age + gender + physical size + fitness) were key to person-centred care and to assessing risk and the need for restrictive interventions. They were less aware of dementia as a social construction and the impact of that construction on the experience of living with dementia (Hankivsky, 2014).

Practice leaders were more able to comment on the wider context of dementia but had limited time with mental health workers to weave this wider knowledge into encounters with them. Further work would be necessary to enable the skill based mental health workers to see beyond the person with dementia in front of them and to visualise the broader context.

In terms of dementia research, the concept of intersectionality is both helpful and relevant. People with dementia are not one large homogenous group. The 850,000 people living with dementia in the UK have commonalities but also differences and intersectionality as an approach to research design can enable studies to question whether experiences are universal and recognise inequality where it exists (Hankivsky, 2012).

5.9 Use of vignettes

As discussed in the chapter three, the vignettes provided the structural component of the interview, rather than being tools within a semi structured interview format. They were deliberately utilised to encourage discussion about an area of practice which is potentially sensitive – restrictive interventions for people with dementia.

There was the possibility that the construction and use of vignettes of service user stories could have constrained or influenced participant responses (Barter & Renold, 1999; Cresswell, 2009; Richards et al, 2007). This theoretical limitation was mitigated by developing and testing the vignettes with mental health workers and enabling discussion of practice experiences. The vignettes facilitated discussion beyond a simple simulated situation which allows a focus on a particular topic. They gradually revealed a practice scenario via a story which was punctuated by sets of questions.

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The questions provided opportunities for participants to disclose real practice examples or to continue a theoretical discussion, allowing the interview conversation to flow while offering choice to the participant. This approached proved to be effective, with most participants identifying with the vignette stories, likening them to experience with people with dementia in their practice experience.

The literature relating to the use of vignettes is limited in terms of the depth and breadth of their use across research designs (Kindemir & Budd, 2018). The efficacy of using vignette versus a more traditional interview format is difficult to evaluate as studies generally utilise them or don't (comparative studies are not available). The challenges of using vignettes effectively were discussed in chapter three and largely relate to the risk that participant responses are influenced by the fictious scenarios and their responses may not be reliable accounts of actual practice.

In this study, the application of vignettes in lieu of a semi structured interview schedule offered a novel contribution to methods research in that there was an opportunity to deepen interview discussions via the use of story linked questions. This approach enabled a structured but engaging discussion about complex and emotive issues, the fictional components of the discussion offering repeated opportunities to participate on a theoretical or personal level. Additionally, real practice discussion was enabled by providing the safety of simulation throughout the interview. Participants could move between the vignette story and actual practice without explicit discussion or declaration. This final point seems particularly relevant to the exploration of sensitive issues in qualitative research.

5.10 Thesis Reflections

At its simplest, a reflective approach requires the researcher to be thoughtful and open. The reflective stance that I adopted was considerably more ambitious, which though challenging and uncomfortable at times, enabled the thesis to be a living document which grew and changed as it progressed. I embraced the use of 'I' and its associated subjective stance to allow me to get nearer to the meaning of participant data and to embrace rather than fear any 'direction changes' in terms of findings, analysis and conclusions.

Models of reflection and reflexivity generally require the researcher to consider their own role in the research process (in terms of power, social position). Intersectionality as an explanatory approach pushed that requirement further in relation to this study, asking that I not only acknowledged the power within the research relationship, but also the diversity of perspectives. Utilising intersectionality as part of the research design recognised the complexity of people's experiences (including my own) and that they belong to multiple social categories which interreact and change over time and across locations (Etherington, 2004; Finlay, 2002).

Participants in this study were largely mature people with many years of clinical experience yet their opinions were seldom heard in relation to complex, contentious practice issues such as restrictive practice for people with dementia. This research gave them a voice which enabled them to, unexpectedly, actively challenge my determination to pursue an intersectional perspective. Following a process of testing and at times frustrating reflection, I have been able to accept that at the outset of the study, I was hoping (albeit unconsciously) to impose my world view onto the study which would neatly lead to an intersectional exploration of restrictive intervention practice challenges. As the interviews and then the analysis progressed, I came to understand that this aspiration was misplaced and I subsequently became more

interested in the views of participants than my own. This reflective process was enabled by the use of interpretive description which encouraged me to manage the tension between engagement with the data and the wider world by adopting a 'head down, head up' approach (intermittently leaving the data to consider wider influences – literature, practice guidance, published opinion). I believe that this assisted me in constructing an objective description which mitigated my influence and prevented significant alteration of the shape and content of participants described experiences.

5.10.1 Reflections on way of knowing

The model of translated ways of knowing (Figure 5.1) details the complexity of learning and ways of knowing which have emerged from this thesis. The knowledge pathways are vertically bi-directional (moving between practice leaders and mental health workers and people with dementia) and also horizontal (moving consciously and tacitly between mental health workers).

As described earlier in the chapter, tacit knowledge cannot be scrutinised or shared, but has the potential to be if a process of supported reflection is undertaken. In restrictive intervention practice, that support can be provided via supervision which can convert implicit understanding into explicit knowledge via a process of examination and discussion. Earlier sections in this chapter also discussed how mental health workers valued restrictive intervention training but were not clear about the importance of supervision. Without regular supervision, tacit knowledge and its transfer between staff is not accessible and therefore cannot be scrutinised, tested or validated. In relation to this study and the host organisation, there is the potential for further development of supervision structures, to enable mental health workers to challenge or influence policy development / practice change.

5.11 Study Limitations and Choices

5.11.1 Sample size

The sample size for the study was relatively small but reflective of the methodological design and in keeping with similar studies included in the literature review (Chapter two). Of the two qualitative studies included (Duxbury, 2013; McDonald, 2007), the sample sizes ranged between eight and fifteen participants. Interpretive description refers to the researcher needing to reach a point whereby they understand 'what is happening here' before being overwhelmed by vast quantities of data (Thorne et al. 1997). The twenty three qualitative interviews which were conducted produced sufficient data for the development of thematic findings but few enough to allow in depth exploration within each participant interview.

5.11.2 The research setting

The study was set in a single NHS Mental Health Trust in England which may have limited the breadth of findings. To mitigate against this limitation, two mental health in-patient facilities sites in two different counties were included (managed by the same Trust) – each was using a different restrictive intervention approach at the time of data collection. The mental health setting for this study was distinct from most settings in relation to the literature review where the majority of studies were set in care homes or non-mental health hospital environments (Tables 2.3 and 2.4). This contrast provided an opportunity to set the investigation in a relatively under researched environment but made links with existing research less compelling.

5.11.3 My influence as a researcher

As discussed in previous chapters, I am a senior manager in the NHS Trust where the study was set which allowed me a greater understanding of the services and this also had the potential to influence recruitment or open engagement in interviews. To minimise this issue, I conducted the interviews in service delivery areas which were not in my management portfolio and constructed a recruitment strategy which enabled a choice of participation without coercion or obligation. When reviewing the literature, my experience of dementia services enhanced my ability to critique: understanding terminology and practice cultures – which was also helpful during the process of analysis of my own data.

5.12 Conclusion

This chapter has explored the themes outlined in Chapter four and considered a theoretical framework of ways of knowing to enable an understanding of the findings (Heron & Reason, 2008). This framework suggests that practice leaders come to know and use information by actively pursuing knowledge via academic routes while frontline mental health workers actively participate in direct training and practice to learn.

The chapter also introduced a 'Model of Translated Ways of Knowing'. This model suggests that the body of knowledge (legislation, case law, policy, research evidence, literature, opinion) which informs restrictive intervention practice is complex, convoluted and shifting. Practice leaders had the time and ability to engage in a process of exploration and understanding - translating that body of knowledge into formats which enabled the organisation to equip their frontline mental health workers. The mental health workers were then able to translate what they had learned via training, supervision and peer support into person-centred dementia practice. The

model also demonstrated that there is considerable complexity in terms of learning and ways of knowing which requires multi-dimensional explanation and management to maximise knowledge transfer.

These findings represent a challenge to organisations which provide care and treatment for people with dementia to recognise, accept and manage this complexity via their organisational development and delivery structures. The 'Model of Translated Ways of Knowing' suggests that the provision of practice leadership is essential in terms of providing translation from law and research into organisational policies, procedures and training curriculums, enabling theory into practice. It further suggests that supervision in practice is essential to ensure that the knowledge which frames practice is overt and accessible to mental health workers, practice leaders and managers.

In service delivery terms, the 'Model of Translated Ways of Knowing' has the potential, when disseminated, to enable policy development and staff training and supervision. It acknowledges that different staff groups can, and do, legitimately receive and understand different levels of knowledge, in different ways. It challenges commissioners, regulators and service providers to look beyond inputs (is every staff member trained to understand and articulate the principles of the MCA) and to judge services on outcomes – do people with dementia receive person-centred, least restrictive interventions?

Chapter 6: Conclusion

6.1 Introduction

The previous discussion chapter sought to provide a bridge between the study findings and this final concluding chapter – by giving meaning to the study findings. The study conclusions were tentatively forming for some time, as the research progressed and the thesis was written. I have been able to test and retest my findings and ideas against my data, going back to the words of participants to check that any conclusions are representative of my dialogue with them.

The aim of this study was to understand how mental health care workers manage restrictive intervention practice when working with people with dementia in an acute mental health setting. This is an important and under-researched area of dementia care which can leave frontline staff delivering complex interventions in a confusing practice arena.

This final chapter aims to summarise the study and consider to what extent the findings have answered the research question. This process of concluding was enabled by the analysis and interpretation of data in previous chapters which provided a framework to construct the conclusions. The broader significance of the findings and the implications for practice and further research will also be considered, (Trafford & Lesham, 2009).

As discussed more fully in Chapter three (methods), the research process for this study was informed by a clear epistemological position that sought to understand

the nature of social meaning – interpretivism.   Additionally, the process was constructionist in terms of ontological understanding, acknowledging evolving and socially produced phenomena (Bryman, 2012; Evans, 2000; Ritchie & Lewis, 2003; Silverman, 2010). Within this deliberately fluid framework, interpretive description facilitated pragmatic choices regarding methods: purposive sampling; use of vignettes within interviews and thematic analysis.

Interpretive description as a methodological approach has rarely been described in the literature. As described in Chapter three, the approach was developed by Thorne (2008) to offer a logical research framework to enable clinical understanding in specific practice areas. In relation to this study, interpretive description has provided a level of flexibility which enabled me to develop ideas about ways of 'knowing' from a complex and diverse set of findings. The process of analysis detailed a rigorous review of data, defining and honing themes leading to the development of the 'Model of Translated Ways of Knowing' – a process which provided an auditable trail of data related decision making.   This new model broadens the understanding of how mental health mental health workers manage restrictive interventions and raises questions about ways of knowing in other areas of healthcare practice, which I will describe further in my recommendations for research later in this chapter.

The process of analysis was shared and discussed with academic supervisors as themes were identified, developed, challenged and redefined (see Appendices 12 and 13).   Additionally, maintaining a reflective approach throughout the research process has contributed to a sense of credibility and rigour and has significantly informed the findings and discussion chapters. Key to that reflective stance has been the continuing acknowledgement of my role as researcher and my attributes as a

nurse and senior NHS manager. This has been central in providing transparency to myself, participants, colleagues, supervisors and readers.

6.2 The Empirical Findings

This empirical study provided findings at a conceptual and practice level. As discussed, mental health workers reported that they struggled with a maze of mental health legislation which was very challenging to navigate and then apply to practice. The knowledge and the challenges which guided and governed restrictive intervention practice were difficult for mental health workers to articulate but were woven into the fabric of care provision. Of particular importance to frontline staff was the restrictive intervention training which was described as impacting on practice in a positive way. Practice leaders described a curriculum which was focussed on conflict resolution, enabling frontline staff to deliver person-centred restrict interventions only when absolutely necessary – as interventions of last resort.

I concluded that the practice leaders were translators of knowledge - they were responsible for reviewing and understanding case law, statutory law, research and expert opinion and then weaving that knowledge into accessible practice vehicles to inform practice: policies, procedures and training curriculums. Additionally, knowledge movement is complex and both conscious and tacit. It moves between practice leaders, mental health workers and people with dementia.

This translation and multi-directional knowledge transfer enabled mental health workers to receive information in accessible and practical formats – which directly informed care plans and approaches for people with dementia.

6.3 Implications for Existing Restrictive Interventions Literature

As previously discussed, the literature provided evidence that education and supervision are valued by staff (Milke et al. 2008; Nakahira et al. 2008; Pellfolk et al. 2010; Testad et al. 2010) and similarly, in my study, I found that mental health workers appreciated restrictive intervention training which was informed by legal frameworks and latest evidence. Secondly, the literature described gender as a participant characteristic across multiple studies, both in terms of people with dementia and care staff. In both cohorts, women significantly outnumbered men, but this was rarely discussed or even commented on. This lack of attention to gender is noted as commonplace by the Alzheimer's Disease International in their report titled Women and Dementia (2015). In this study, I found that mental health workers held an awareness of the attributes of individual service users rather than a broader gender awareness that may be useful in relation to informing environments and supporting both service users and staff. This absence of gender discussion and awareness in the literature or the findings of this study is worthy of further attention, particularly within a wider discussion of intersectionality and its relevance to restrictive intervention practice.

6.4 The Implications for Practice

This study aimed to develop a contextual understanding to answer the research question, rather than produce any findings that might be generalised (Bryman, 2012). The findings do however challenge expectations placed on frontline mental health workers in terms of knowledge about the complexities of restrictive intervention practice. The study found that these expectations were unrealistic and unworkable. The organisation which hosted the research had invested in senior clinical leadership

which 'translated' knowledge for mental health workers. This enabled person-centred and least restrictive practice in the dementia care environments.

Utilising the 'Model of Translated Ways of Knowing', three key areas for change are identified – for organisations, educational delivery and for commissioners and wider bodies such as the Care Quality Commission (CQC):

1. Organisations should revisit knowledge expectations in relation to that which frontline mental health workers are expected to know about restrictive intervention practice. Investment is required in clinical leadership functions which enable the translation of law and national policy guidance into local policy and the construction of training and supervision programmes.

2. In educational terms, the curricula for restrictive intervention training should translate the legal and theoretical guidance into practical approaches which lead with conflict resolution to enable least restrictive practice. Training content should include raising awareness of tacit knowledge and a recommendation that supervision is sourced to ensure best practice.

3. Commissioners and wider regulatory bodies such as the CQC should reconsider how they assess restrictive intervention best practice. Person-centred least restrictive approaches may not be dependent on a nuanced understanding of law and national policy.

6.5 The Contribution to Knowledge

As referred to above, the contribution of this research relates to the development of the 'Model of Translated Ways of Knowing', acknowledging the importance of investment in practice leadership and the person-centred approaches of frontline mental health workers – driven by direct training and supervision, rather than by a nuanced interpretation of legislation.

The findings of this research suggest that frontline staff largely do not have the time and thinking space to translate for themselves. They need to be given the information in an accessible format – if they cannot analyse and synthesise for themselves, then without support, they are set up to fail. The Positive and Proactive Care (2014) document, the recent review of the DoLs (2009) legislation and the draft Bill via the Law Commission continue to criticise services and frontline staff for lack of understanding and implementation of least restrictive approaches. My research suggests that this criticism may be misplaced and that approaches which are articulated by mental health workers as person-centred, may also be least restrictive.

Additionally, the use of vignettes as structures which frame qualitative interviews offer a novel contribution to research methodology approaches. Participants responded positively to this approach and offered responses within the supportive confines of the vignettes which they could declare as their own practice examples or relate directly to the patient stories.

6.6 Recommendations for Practice

1. Mental health settings are frequently managing people with complex dementia. Investment in clinical leadership and supervision is recommended in mental health settings which provide care and treatment for people with dementia to ensure that the most vulnerable people with dementia have access to care practices informed by knowledge translation.

2. The need for 'Translated Ways of Knowing' may apply to other specialities – particularly where mental capacity and decision making may be compromised. Further qualitative research in palliative care, or learning disability settings may enable organisations and practice leaders to manage the complexities of managing law and legislative frameworks and how best to support mental health workers and improve outcomes for service users and carers.

3. The role and value of clinical leadership is often debated in times of economic austerity. Further qualitative research with practice leaders would enable their role as translators to be further explored and clarified, potentially strengthening the case for clinical leadership in other care and treatment environments.

6.7 Recommendations for Research

1. The literature review undertaken as part of this study indicated that people with dementia are rarely engaged as participants in research and found no examples of people with dementia being asked about their experiences of restrictive interventions (including my study which included staff only as participants).

Future qualitative, quantitative and longitudinal studies could enable the voice of people with dementia to be heard – exploring their experiences of receiving restrictive interventions.

2. The care environment for people with dementia has a comprehensive evidence base but there is little research related to restrictive interventions for people with dementia and the practice environment. This study has suggested that the environment, particularly in relation to single bedrooms versus shared bedrooms may impact on thresholds for restriction (none of the studies included in the literature review set out to investigate this issue or reported related findings). Further research in this area may inform the design and modernisation of care and treatment settings and facilitate investment into dementia care environments.

3. The relationship between clinical leadership and service user outcomes is well documented (Kings Fund, 2015) but my literature review did not find any evidence specifically linking clinical leadership to people with dementia and restrictive intervention levels. Further research which explores ways of knowing (both conscious and tacit) which inform restrictive intervention practice could be helpfully undertaken across different care settings.

4. Further research is recommended to investigate the issue of intersectionality and specifically gender in relation to dementia care and treatment. This study found that mental health workers have limited intersectional / gender awareness beyond the concepts of individualised and person-centred care. Future studies may benefit from an ethnographic approach which would enable the further exploration of dementia as a social construction

6.8 Conclusion

The context of restrictive interventions for people with dementia has been subject to very little research in the UK or in other countries. This study has identified and described the complexity of the practice environment in which restrictive interventions take place. The study found that mental health care staff strive to deliver person-centred care in practice – which includes the delivery of restrictive interventions.

This fundamental approach is enabled when the law, policy, research and expert opinion are translated into accessible practice guidance which puts the person with dementia at the centre of all care and treatment.

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Appendix 1: Research setting

A Single NHS Foundation Trust providing mental health and learning disability services across two English counties

Site 1

- I6 beds for people with dementia

- All single ensuite bedrooms

- Positive Behaviour Management (PBM - physical intervention approaches tailored to vulnerable groups)

Site 2

- I2 beds for people with dementia

- Two single rooms

- Two x four bedded single sex dormitories

- Positive Management of Violence & Aggression (PMVA - physical intervention approaches tailored to adults with mental health issues)

V17.2

Appendix 2: Literature quality assessment tool

Data Extraction Tool	Review comments : Study Paper 1 Date of review:	Review comments: Study paper 2 Date of review:	Review comments: Study paper 3 Date of review:	Review comments: Study paper 4 Date of review:	Review comments: Study paper 5 Date of review:	Review comments : Study Paper 6 Date of review:
General information:				Exclude - not restraint		Link to study 10
Date of data extraction						
Date of Study	2014	2011	2013	2004	2007	2006
Identification features of the study:						
Study number(identifier)	JF1	JF2	JF3	JF4	JF5	JF6
Author	Manthorpe et al	Pulsford et al	Duxbury et al	Miskelly	Macdonald	Fossey et al
Article title	Dem Nurses Exp of the MCA2005: A follow up study	A survey of staff attitudes & responses to pwd who are aggressive in res. Care settings	Staff and relatives perspectives on the aggressive behaviour of older pwd in residential care: A qual. Study	a novel system of elctronic tagging in pwd & wandering	Care assistants' views and experience of 'challenging behaviour' in dementia	Effect of ennanced psychosocial care on antipsychotic use in nursing home residents with severe dementia: cluster
Type of publication Country of origin	UK	UK	UK	UK	UK	UK
Study characteristics						
Aim/objectives of the study	to explore understanding of the MCA	to explore paradigms of understanding of dementia	to understand the reasons for and ways to respond to aggression		To explore the views and experiences of care assistants	to evaluate the effectiveness of a training and support intervention for nursing home staff in reducing the proportion of residents with dementia who are
Study design	Qual Interviews x 15. Phase 2 of a 2 phase study	Quant - survey + incident audit	Qual - Interviews with staff and focus groups with		Qual- qaire (background info) + interviews	Quant - cluster randomised trial
Inclusion / exclusion criteria						
Recruitment procedures. Registered / Non-Registered practitioner	Reg Nuses (CDNs and Admiral N's)	4 x nursing homes - all staff invited to complete an attitude q'aire and incident forms for aggression	4 x care homes Interviews with 8 staff (4 x manager / 2 x nurse / 2 x HCA)		2 x care homes (20 beds / 15% pwd) Qaire to staff (n=NK) then interviews n= 10	12 homes for pwd in London, Newcastle and Oxford
Profession	Nurse	all staff (15 nurses / 21	as above		care assistants	residents in receipt
Participant characteristics						NK
Age	range 30-70yrs	NK	20-55yrs		most 41-50	
Gender	14 x F / 1 x M		6 x F / 2 x M		NK	
Sexuality	NK		NK		NK	
Ethnicity	NK				NK	
Intervention and setting						
Setting (MH hospital / unit)	Community	Bupa care homes	Care homes		care homes	care homes
Description of the intervention(s) eg:	Interviews	MAPDAQ - attitude q'aire (dev. For this study) + SOAS-R inc. Form	Interviews / Focus Groups		Qaires and interviews	Quant - cluster randomised trial
Type / level of restrictive intervention		N/A	see definition on notes tab		defined only as challenging behaviour	px or neuroleptics - chemical rstraint
Outcome data/results	↑ understanding					
Assessment tools used		MAPDAQ - attitude q'aire + SOAS-R inc. Form	prompts from Duxbury's (2002) model of aggression causation & management		qaire - background info	cohen-mansfield agitation inventory (levels of agitaiton) + px of neuroleptics
Data analysis tools / methods used	Thematic analysis	descriptive statistics for both sets of data	content analysis		NK	
Types of intervention	Interviews				qaires / interviews	randomisation - 6 care homes givne training and support - 6 TAU
Number of participants	15	36	8		10 interviews	174 residents in the intervention arm / 164 TAU
Number of withdrawals, exclusions, lost to follow-up	Not known	NK	NK		NK	23 excluded - other MI present

Appendix 3: Literature Search 2015 results

```
┌─────────────────────────┐
│ 1028 studies identified │
│   via search strategy   │
└─────────────────────────┘
             │                          ┌──────────────────────────┐
             ├──────────────────────────▶│ 877 studies excluded via │
             │                          │    title or abstract     │
             ▼                          └──────────────────────────┘
┌─────────────────────────┐
│ 151 Full text studies   │
│       identified        │
└─────────────────────────┘
             │                          ┌──────────────────────────┐
             ├──────────────────────────▶│ 7 studies via hand       │
             │                          │ searching / back chaining│
             ▼                          └──────────────────────────┘
┌─────────────────────────┐
│ 158 Full text studies   │
│        total            │
└─────────────────────────┘
             │                          ┌──────────────────────────┐
             ├──────────────────────────▶│ 139 studies excluded     │
             │                          │ (repeats, did not meet   │
             │                          │        criteria)         │
             ▼                          └──────────────────────────┘
┌─────────────────────────┐
│ 19 studies identified   │
│      for review         │
└─────────────────────────┘
             │                          ┌──────────────────────────┐
             ├──────────────────────────▶│ Further review – 1 more  │
             │                          │ study excluded - (did not│
             │                          │      meet criteria)      │
             ▼                          └──────────────────────────┘
┌─────────────────────────┐
│ 18 studies included in  │
│  the literature review  │
└─────────────────────────┘
```

Appendix 4: Literature Search 2016 - 2017 results

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┌─────────────────────────┐
│  783 studies identified  │
│  via search strategy     │──────────────────────────────┐
└─────────────────────────┘                                │
             │                              ┌───────────────────────────────┐
             │                              │ 750 studies excluded via       │
             └──────────────────────────────▶ title or abstract              │
             │                              └───────────────────────────────┘
┌─────────────────────────┐
│ 33 Full text studies     │
│ identified               │
└─────────────────────────┘
             │                              ┌───────────────────────────────┐
             │                              │ 0 studies via hand searching   │
             └──────────────────────────────▶ / back chaining                │
             │                              └───────────────────────────────┘
┌─────────────────────────┐
│ 33 Full text studies     │
│ total                    │
└─────────────────────────┘
             │                              ┌───────────────────────────────┐
             │                              │ 27 studies excluded            │
             └──────────────────────────────▶ (repeats, did not meet         │
             │                              │ criteria)                      │
             │                              └───────────────────────────────┘
┌─────────────────────────┐
│ 6 studies identified for │
│ review                   │
└─────────────────────────┘
             │                              ┌───────────────────────────────┐
             │                              │ Further review – 2 more        │
             └──────────────────────────────▶ studies excluded - (did not    │
             │                              │ meet criteria)                 │
             │                              └───────────────────────────────┘
┌─────────────────────────┐
│ 4 additional studies     │
│ included in the          │
│ literature review        │
└─────────────────────────┘
```

Appendix 5: Scoping the literature search 2015

Data bases and results:

Database	Search Terms	Parameters	Citations identified via search strategy	Citations identified via title /abstract (full text obtained)	Citations Included after full text review
Academic Search Complete	dementia and restraint	2005-2015 English Language research	131	13	3
	dementia and physical restraint	2005-2015 English Language research	74	12	1
	dementia and staff and restraint	2005-2015 English Language research	31	16	2
	dementia and staff and physical restraint	2005-2015 English Language research	22	16	0
Total included					**6**
Web of science	dementia and restraint	2005-2015 English Language research	207	10	1
	dementia and physical restraint	2005-2015 English Language research	121	6	

	dementia and staff and restraint	2005-2015 English Language research	58	11	1
	dementia and staff and physical restraint	2005-2015 English Language research	45	3	2
Total included					5 (**4** new) Sub total 10
Medline, Cinahl, Psychinfo; Cochrane; PubMed.	dementia and restraint	2005-2015 English Language research	147	12	1
	dementia and physical restraint	2005-2015 English Language research	127	21	1
	dementia and staff and restraint	2005-2015 English Language research	34	16	1
	dementia and staff and physical restraint	2005-2015 English Language research	31	15	0
Total included					3 (2 new) Sub total 12

Google Scholar	dementia and restraint	2005-2015 English Language research	15,600	N/A	0
	dementia and physical restraint	2005-2015 English Language research	17,600	N/A	0
	dementia and staff and restraint	2005-2015 English Language research	15,700	N/A	0
Total included					0 Sub total 12
Hand Search of recent journals					**3**
Articles sourced via reference lists					**3**
					<u>**6**</u> **Total 18**

<u>The process was updated in 2017 yielding a further 4 studies = **Final total 22**</u>

Appendix 6: Participant Invitation Letter (Interviews Groups 1 & 2)

Dear Colleague,

I am carrying out a qualitative research study titled:

Understanding the nature of restrictive intervention management by mental health care workers in an acute mental health setting for people with dementia.

This research project is part of a PhD programme of study at Lancaster University and will involve participation in an interview lasting approximately one hour. With your agreement, the interview will take place at your place of work to avoid travel time and expense.

I am hoping that you will agree to take part in this study. Participation is on a voluntary basis and all information is given anonymity.

Please read the attached participant information sheet and consent form and consider whether you would like to take part. If you require further information, please email me directly using the contact details below.

If you would like to participate, please return the response form below in the addressed envelope provided (Trust internal mail).

Yours sincerely,

Jan Furniaux
PhD Student
Contact details:
Researcher:
janfurniaux@lancs.ac.uk
Lancaster University,
Lancaster, LA1 4YG

....

Response Form
I am interested in taking part in the research study called:

Understanding the nature of restrictive intervention management by mental health care workers in an acute mental health setting for people with dementia.

Appendix 7: Interview schedule Group 1

1.	Introductions **Please note that vignettes are fictitious**
2.	Verbal Consent Check
3.	Icebreaker Exercise
4.	Vignette: Question Set 1 Question Set 2 Question Set 3
5.	Discussion Participants asked to discuss vignettes (introducing practice experience if they wish to do so)
6.	Interview Closure

Appendix 8: Interviews – Vignette one

Characteristics of the Service User: *Sarah Thompson*
Please note that this is a fictitious vignette

Characteristics	Description
Age in years	62yrs old, retired
Marital Status	Married
Gender	Female
Diagnosis	Alzheimers Dementia, early onset
Admission	Informal admission in Best Interests (MCA, 2005)
Physical characteristics	Physically well, 5ft 5 inches tall, weight: 8.5 Stones
Carer involvement	Usually lives with husband in rural location. Husband visiting each day.

Sarah is admitted to the ward. She does not have capacity to consent to being admitted to a mental health hospital. She has been admitted as a Best Interest decision due to safety concerns.

On admission Sarah walks continuously around the ward and bangs on the doors to the corridor areas and the doors to the garden area and main entrance. All these doors have a key fob lock.

Her husband Mike is with her when she is admitted and reports to the admitting nurse that Sarah walks their dogs every day for several miles in the countryside where they live. It was during their walk yesterday that he was unable to persuade Sarah to walk with him in the right direction for home which led to her subsequent admission. He says that now she is in hospital with these locked doors she will be like a 'caged animal'. He is fearful of how this will affect her.

Question Set 1

How do you think the admitting nurse should respond to Mike?
How might you respond?
What might the prescribed care plan for safety needs relating to her walking be?

Mike also explains to the admitting nurse that he has had increasing difficulty supporting Sarah with meeting her hygiene needs at home. At times she will go into the shower if he goes in with her and she will occasionally use the toilet when prompted though increasingly does not appear to recognise what it is. He says that he is really worried that she will be 'put in nappies'.

When the staff later approach Sarah to support her with changing into her night clothes she becomes very distressed pushing staff away and saying 'not this - no I don't' and repeating 'it isn't, it isn't' . Sarah does not have capacity to make decisions relating to her personal care needs.

<u>Question Set 2</u>

What should the staff members do next?
What would you do?

A decision is made to support Sarah to sleep in her clothes and eventually she settles to sleep. During the night, staff check Sarah regularly: at 02.00hrs she is out of the bed having been incontinent of faeces and urine. Staff attempt to direct her to the bathroom and she immediately tries to leave the room.

<u>Question Set 3</u>

What should the staff and you do next?

<u>Question</u>

<u>Set 4</u>

Actual practice examples (if introduced by the participant)
What did you do?
Are there any circumstances where your restrictive intervention approaches might change?

Appendix 9: Interviews: Vignette two

Please note that this is a fictitious vignette
<u>Characteristics of the Service User:</u> *Mike Thompson*

Characteristics	Description
Age in years	62yrs old, retired
Marital Status	Married
Gender	Male
Diagnosis	Alzheimers Dementia, early onset
Admission	Informal admission in Best Interests (MCA, 2005)
Physical characteristics	Physically well, 5ft 11 inches tall, weight: 12.5 Stones
Carer involvement	Usually lives with wife in rural location. Wife visiting each day.

Mike is admitted to the ward. He does not have capacity to consent to being admitted to a mental health hospital. He has been admitted as a Best Interest decision due to safety concerns.

On admission Mike walks continuously around the ward and bangs on the doors to the corridor areas and the doors to the garden area and main entrance. All these doors have a key fob lock.

His wife Sarah is with him when he is admitted and reports to the admitting nurse that Mike walks their dogs every day for several miles in the countryside where they live in the Forest of Dean. It was during their walk yesterday that she was unable to persuade Mike to walk with her in the right direction for home which led to his subsequent admission. She says that now he is in hospital with these locked doors he will be like a 'caged animal'. She is fearful of how this will affect him.

<u>Question Set 1</u>

How do you think the admitting nurse should respond to Sarah?
How might you respond?
What might the prescribed care plan for safety needs relating to his walking be?

Sarah also explains to the admitting nurse that she has had increasing difficulty supporting Mike with meeting his hygiene needs at home. At times he will go into the shower if she goes in with him and he will occasionally use the toilet when prompted though increasingly does not appear to recognise what it is. She says that she is really worried that he will be 'put in nappies'.

When the staff later approach Mike to support him with changing into his night clothes he becomes very distressed pushing staff away and saying 'not this - no I don't' and repeating 'it isn't, it isn't' . Mike does not have capacity to make decisions relating to his personal care needs.

Question set 2

What should the staff members do next?
What would you do?

A decision is made to support Mike to sleep in his clothes and eventually he settles to sleep. During the night, staff check Mike regularly: at 02.00hrs he is out of the bed having been incontinent of faeces and urine. Staff attempt to direct him to the bathroom and he immediately tries to leave the room.

Question Set 3

What should the staff do next?
What would you

do?

Question Set 4

Actual practice examples (if introduced by the participant)
What did you do?
Are there any circumstances where your restrictive intervention approaches might change?

Appendix 10: Transcription confidentiality form

Confidentiality Agreement for the Transcription of Qualitative Data

Name of Study:	*Understanding the nature of restrictive intervention management by mental health care workers in an acute mental health setting for people with dementia.*
Study PI:	Jan Furniaux

In accordance with the Research Ethics Committee at Lancaster University (UREC), all participants in the above-named study are anonymised. Therefore any personal information or any of the data generated or secured through transcription will not be disclosed to any third party.

By signing this document,
you are agreeing:

- not to pass on, divulge or discuss the contents of the audio material provided to you for transcription to any third parties
- to ensure that material provided for transcription is held securely and can only be accessed via password on your local PC
- to return transcribed material to the researcher when completed and do so when agreed in password protected files
- to destroy any audio and electronic files held by you and relevant to the above study at the earliest time possible after transcripts have been provided to the research team, or to return said audio files.

Your name (block capitals) _____

Your signature _____

Date _____

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Appendix 11: Group 2 Interview schedule

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Interview Guide: Questions	Notes and Observations
Introduction: Brief outline of the study; re-gain permission to digitally record the interview. (**Please note that vignettes are fictitious**) 1. Can you describe to me your role as an practice leader? (profession and length of experience) 2. Can you tell me about your role with people who have dementia? . 3. Can you describe restrictive intervention management in relation to dementia (Mental Health Act, Mental Capacity Act, Deprivation of Liberty Safeguards, Case Law), working at a strategic and practice development level within the NHS Trust. 4. Can you explain the practice issues in relation restrictive interventions for people with dementia? 5. What are the practice challenges for restrictive interventions for people with dementia?	
Post-interview comments:	

Appendix 12: Coding chart

All Codes Phase 1 & 2 July 2016		
Attendance at Positive Behaviour Management (PBM) training	Access to Supervision	Staff acknowledging gender and carer issues
Attendance at Prevention & Management of Violence & Aggression (PMVA) Training	Access to supervision – 'if you ask for it'	Professional protection – staff avoiding allegation of assault
The importance of de-escalation	The importance of MDT discussion and peer support	Staff disregard for gender and carer preference
Training to use covert medication	'Common Sense'	Female pts should be asked if male carers are acceptable
A lack of understanding what it means to 'detain' a pt	Availability of specialist mental health workers	Advocating 'gender matching' where possible
The pragmatic approach – you use the staff available	Importance of support for novice mental health workers	People are individuals – different preferences
Expression of stereotypical views	Experience informing practice and knowledge by experience	We need to ask about gender and carer preferences
The importance of historical abuse issues + gender and carer preference	The workload is too high	The fluid nature of gender related acceptance of care
Assessing risks to the pt	Giving time to pts is essential	Increasing age decreases gender and carer preference
Assessing risks to staff	There is not enough time	The importance of clinical judgement
Assessing the risk of falling	There is a perception of not enough time	Positive risk taking

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Assessing the risk of absconding	*Using 'loaded' language to describe male pts*	*The risk of secondary impact of restrictive intervention: distress, harm*
Assessing the risk of skin breakdown	*Expression of stereotypical beliefs*	*Ways to mitigate risk*
Assessing the risk to others	*Describing walking as wandering*	*Promoting safety*
Assessing the risk of self-neglect	*Using the MCA*	*The importance of assessment to define risk*
Trying to 'do the right thing' for the pt	*Using DoLs*	*Confusion about legislation*
Making decisions as a team	*Using the MHA*	*We must listen to carers*
Trying to be least restrictive	*Legislation to give medication*	*Life history work is key*
Intervening in Best Interest	*The carer is the historian for the pt*	*Carers are important*
Giving clarity to the pt and carer	*Assessment is important*	*Carers need information*
Upholding professional obligations	*Records and care plans*	*Loaded language about male pts*
Involve carers in RI planning and feedback	*Uniforms identify helpers*	*Staff are stressed*
Fear of getting it wrong	*The person needs accessible information*	*It's so complex it's a minefield*
'registered' training majors in the MHA	*Voice tone is relevant*	*AMHP training emphasises least restrictive practice*
You need to use yourself as a communication tool	*Restrictive Interventions are a last resort*	*Ask - Is this the least restrictive option?*
A 'fresh face' approach works	*Being positive about PBM*	*Observation is an RI*
Staff should take responsibility for trying to understand the person	*Being positive about PMVA*	*De-escalation is first and foremost*

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Dementia needs innovative communication	We see medication as a restrictive intervention	Physical interventions are less restrictive than medication
These are normal behaviours in an abnormal setting	We see covert medication as a restrictive intervention	Age is a characteristic which affects RI practice
Share the care and control with carers	The ward environment restricts everyone	Gender is a characteristic which affects RI practice
Carers need support to understand what is going on for the person	The ward environment can be designed to promote least restriction	Physical size and fitness is a characteristic which affects RI practice
Build positive relationships	Plan the RI – be prepared	Continence aids are a form of restriction
Be consistent	Nominate a leader for every RI	Frailty is a characteristic which affects RI practice
You need a team approach to RI decision making	Female staff can assist de-escalation	Size matching is more important than gender
Gender 'awareness' is there – but expressed in practical terms (tacit?)	Being least restrictive does take time with the pt	Shared bedrooms are restrictive – they lower the threshold for RI's
The staff are in a position of power	Legislation guides safeguarding practice	Legislation lends sophistication to care delivery
We must be clear about why – when we use RI's	Pre-MCA – de-facto detention was practiced	The Bournewood ruling changed things
All people are individuals	Pre-MCA there was a patriarchal approach.	Pre-legislation there was more task orientation
You must know the pt	Pre-MCA – someone with dementia was presumed to lack capacity	2 sets of legislation = complexity at the interface
Use distraction first	There is a misappropriation of 'an assumption of capacity'	Capacity is sometimes used as a currency to access services
Use occupation first	There is a 'well-meaning disregard and negation' of the MCA	The legislation is forever a minefield

There are professional disputes about DoLs and MHA application	*The MHA process demands evidence of least restrictive consideration*	*Compliant and incapacitated pts – are probably now detained*
The MHA provides safeguards for pts that the MCA does not	*AMHPs have differing opinions about MHA and DoLs*	*Staff refer to Policy and not the law*
BME as a characteristic that impacts on RI	*National strategies have increased awareness of RI*	*Physical intervention (PI) policy advises gender matched teams*
You need enough trained staff to make a PI team – so all have to be trained in the same approach	*PMVA approaches can be risky for older people*	*All older adults should be restrained using the same approach*
We need data to understand RI's	*We need to separate PI for personal care and PI for V&A*	*PI promotes a graduated approach*
It's better to avoid admission (and therefore restriction) altogether	*There is a national postcode lottery for services*	*Environmental restrictions increase behaviours that challenge*
The MHA = longer admissions = more restrictions	*The MCA drives least restrictive practice*	*Ward staff understand least restriction – they don't understand the law*
The Cheshire West ruling changed practice	*The MHA can mean free aftercare via 117 – which is a good thing for pts*	*Detention is detention – it makes no difference to the pt*
PI training = least restrictive first	*PI training = try not to use PI*	

143 codes

RI – Restrictive Interventions

Appendix 13: Coding chart (themes for review)
(P1 and P2: Participants Groups 1 & 2)

No	P1	P2	Codes	Sub Theme	**Theme for review 1**
1.1	√		Attendance at Positive Behaviour Management (PBM) training	Staff Intervening as trained	The knowledge which guides restrictive intervention practice – the sources
1.1.1	√		Attendance at Prevention & Management of Violence & Aggression (PMVA) Training		
1.2	√		The importance of de-escalation		
1.4	√		Training to use covert medication		
1.15		√	Registered training is majors in the MHA		
1.16 and 1.17		√	AMHP training – emphasises least restriction		
1.18		√	PI training = least restrictive first		
1.19		√	PI training = try not to use PI		
				Sub Theme	
1.3	√		Access to Supervision	The importance of supervision	
1.11	√		Access to supervision – 'if you ask for it'		
1.8	√		The importance of MDT discussion and peer support		
1.14		√	It's so complex it's a minefield		

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No	P1	P2		Sub Theme	
1.6			'Common Sense'		
1.9	√		Availability of specialist mental health workers	Novice to expert – the need for different levels of support	
1.10	√		Importance of support for novice mental health workers		
1.7and1.12	√		Experience informing practice and knowledge by experience		
1.13		√	Fear of getting it wrong		

No	P1	P2	Codes	Sub Theme	**Theme for review 2**
2.1	√		Staff acknowledging gender and carer issues	Overt awareness of gender	
2.11	√		Professional protection –staff avoiding allegation of assault		
2.2	√		Staff disregard for gender and carer preference		
2.16	√		Female pts should be asked if male carers are acceptable		
2.17		√	Female staff presence can assist de-escalation		
				Sub Theme	
2.14	√		The pragmatic approach – you use the staff available		
2.8	√		Expression of stereotypical views		

No	P1	P2	Codes	Sub Theme	Theme for review 3
2.12	√		The importance of historical abuse issues + gender and carer preference	The choice limiting reality of the ward setting	Gender awareness – 'the water we swim in?'
2.19		√	PI policy advises gender matched teams – not always possible		
				Sub Theme	
2.10	√		Advocating 'gender matching' where possible	Person-centred and gender awareness	
2.9	√		People are individuals – different preferences		
2.13	√		We need to ask about gender and carer preferences		
2.7	√		The fluid nature of gender related acceptance of care		
2.15	√		Increasing age decreases gender and carer preference		
2.18		√	Staff are gender aware – but it's expressed in practical terms		

No	P1	P2	Codes	Sub Theme	Theme for review 3
3.1	√		The workload is too high	The time factor	A perception of time to care
3.3	√		Giving time to pts is essential		
3.4	√		There is not enough time		
3.5	√		There is a perception of not enough time		
3.6	√	√	Being least restrictive takes time		

No	P1	P2	Codes	Sub Theme	Theme for review 4
4.1	√		Assessing risks to the pt	Structured approaches to risk	The risk of risk management
4.2	√		Assessing risks to staff		
4.3	√		Assessing the risk of falling		
4.4	√		Assessing the risk of absconding		
4.5	√		Assessing the risk of skin breakdown		
4.6	√		Assessing the risk to others		
4.7	√		Assessing the risk of self-neglect		
				Sub Theme	
4.8	√		Using 'loaded' language to describe male pts	'old culture' approaches	
4.12	√		Expression of stereotypical beliefs		
4.13	√		Describing walking as wandering		
				Sub Theme	
4.11	√		The importance of clinical judgement	Innovative thinking about risk	
4.16	√		Positive risk taking		
4.15	√		The risk of secondary impact of restrictive intervention: distress, harm		
4.10	√		Ways to mitigate risk		
4.9	√		Promoting safety		
4.14	√		The importance of assessment to define risk		

No	P1	P2	Codes	Sub Theme	**Theme for review 5**
5.1	√		Using the MCA	The legal rules provide a framework for practice	
5.1.1	√		Using DoLs		
5.2	√		Using the MHA		
5.9	√		Legislation to give medication		
5.13		√	Legislation guides safeguarding		
5.14		√	Legislation = sophisticated care delivery		
5.26		√	MHA demands evidence of least restriction – so is protective		
5.27		√	Compliant + incapacitated = detained = clarity		
5.28		√	MHA = safeguards for pts (eg: appeal)		
5.31		√	MCA drives least restrictive practice		
					Sophisticated legislative framework vs 'benign disregard' in practice?
				Sub Theme	
5.5	√		Trying to 'do the right thing' for the pt	Person-centred approaches to using legislation	
5.10	√		Making decisions as a team		
5.12	√		Trying to be least restrictive		
5.11	√		Intervening in Best Interest		
5.4	√		Giving clarity to the pt and carer		
5.8	√		Upholding professional obligations		
5.32		√	Ward staff do understand least restrictive practice (but not the law)		
5.35		√	MHA and MCA – makes no difference to the pt		
				Sub Theme	
5.3	√		A lack of understanding what it means to 'detain' a pt		

No	P1	P2	Codes	Sub Theme	Theme for review 6
5.7	√		Confusion about legislation	The law is a mess	
5.20		√	The MCA and MHA interface is too complex for practice		
5.23		√	A well-meaning disregard of the MCA		
5.24		√	It's a minefield and a dog's dinner		
5.25 and 6.29		√	Profs and AMHPs MHA and DoLs disputes		
5.30		√	Staff don't use the law – they use policy and training		

No	P1	P2	Codes	Sub Theme	Theme for review 6
6.1	√		We must listen to carers	Using the tools	Communication as a foundation for interventions
6.2	√		Life history work is key		
6.3	√		Carers are important		
6.4	√		Carers need information		
6.5	√		The carer is the historian for the pt		
6.12	√		Assessment is important		
6.16	√		Records and care plans		
6.18	√		Uniforms identify helpers		
6.21	√		The person needs accessible information		
6.22	√		Voice tone is relevant		
				Sub Theme	
6.6	√		Loaded language about male pts	It's not an easy place to	
6.15	√		Staff are stressed		

No	P1	P2		Codes	Sub Theme	
				work		
					Sub Theme	
6.7	√		You need to use yourself as a communication tool			
6.8	√		A 'fresh face' approach works			
6.9	√		Staff should take responsibility for trying to understand the person			
6.10	√		Dementia needs innovative communication			
6.14	√		These are normal behaviours in an abnormal setting		Thinking outside of the box	
6.13	√		Share the care and control with carers			
6.19	√		Carers need support to understand what is going on for the person			
6.20	√		Build positive relationships			
6.23	√		Be consistent			

No	P 1	P 2	Codes	Sub Theme	Theme for review 7
7.1	√		Restrictive Interventions are a last resort		
7.2	√		Being positive about PBM		
7.3	√		Being positive about PMVA		
7.4	√		We see medication as a RI		
7.4.1	√		We see covert medication as a RI		
7.15	√		The ward environment restricts everyone		
7.26	√		The ward environment can be designed to promote least restriction	Training theory into practice	
7.18	√		Plan the RI – be prepared		
7.19	√		Nominate a leader for every RI		

7.23 and 34	√		Ask - Is this the least restrictive option?		
7.24	√		Observation is an RI		
7.10	√		De-escalation is first and foremost		
7.28	√		PI's are less restrictive than medication		
7.30		√	PBM v PMVA – you need enough staff trained in the same approach to make a team -		
7.31		√	PMVA - ↑ risk of injury to pwd		
7.32		√	PI formats for all pwd should be the same (PBM)		
				Sub Theme	
7.6	√		Age is a characteristic which affects RI practice		
7.7	√		Gender is a characteristic which affects RI practice		
7.8 and 25	√		Physical size and fitness is a characteristic which affects RI practice	The things that impact practice	'what drives RI practice on the ground'
7.9	√		Continence aids are a form of restriction		
7.20	√		Frailty is a characteristic which affects RI practice		
7.21	√		Size matching is more important than gender		
7.27	√		Shared bedrooms are restrictive – they lower the threshold for RI's		
				Sub Theme	
7.5	√		You need a team approach to RI decisions		
7.33		√	PI for pwd is about p.care not V&A		
7.11	√		The staff are in a position of power		
7.12	√		We must be clear about why – when we use RI's	Reflectiv	

No	P1	P2	Codes	Sub Theme	Theme
7.13	√		All people are individuals	e RI practice	
7.14	√		You must know the pt		
7.16	√		Use distraction first		
7.17	√		Use occupation first		
7.22	√		Involve carers in RI planning and feedback		

No	P1	P2	Codes	Sub Theme	Theme for review 8
8.15		√	Pre-MCA = defacto detention	Legal Hx	
8.16		√	Bournewood – landmark judgement		
8.17		√	Pre-MCA – Patriarchal approach		
8.18		√	Pre-MCA – task orientation		
8.19		√	Pre-MCA: Dementia = lacks capacity		
8.33		√	Cheshire West ruling – changed practice		
8.34		√	MHA = longer admission = ↑ restriction		
				Sub Theme	
8.21		√	There is a mis-use of the 'assumption of capacity'	practice implications	Miscellaneous
8.22		√	Capacity is used as a 'currency' to access services		
8.34		√	MHA (Sec 3) = access to free Sec 117 aftercare – benefit to pt and cost to the system		
8.29		√	BME as a characteristic that impacts on RI		
8.35		√	Better to avoid admission at the start (medics re: vignettes)		
8.36		√	Postcode lottery for services – crisis team for pwd		

Appendix 14: Participant Information Sheet (Groups 1 & 2)

(Group 1 Interviews)

Title of Study:

Understanding the nature of restrictive intervention management by mental health care workers in an acute mental health setting for people with dementia.

My name is Jan Furniaux and I am conducting this research as a student in the PhD Mental Health programme at Lancaster University, Lancaster, United Kingdom.

What is the study about?

The purpose of this study is to explore the understanding of restrictive intervention management by mental health care workers (non-registered staff and registered health care professionals) involved in the care and treatment of people with dementia.

The study will use interviews to collect data which will take place on Trust premises during the working day - whilst every effort will be made; it is not possible to ensure confidentiality of participation.

You are being asked to participate in an interview.

Why have I been approached?

You have been approached because the study requires information from people who are mental health care workers involved in the care and treatment of people with dementia. The study will be set within the dementia in-patient unit.

Do I have to take part?

No. It's completely up to you to decide whether or not you take part - participation in this study is voluntary. You are welcome to withdraw from the study at any time up to a week after the interview. Taking part will have no negative consequences for you.

What will I be asked to do if I take part?

If, after reading the participant information, you agree to take part, you will be asked to complete a consent form.

You will be asked to participate in an interview with the researcher for approximately 60-90 minutes. The interview will take place during work time, at your work place: a convenient time will be agreed with you. The interview will be audio taped. The content of the interview will relate to your experience, as a mental health care worker in relation to restrictive intervention management when working with people with dementia. A semi-structured interview schedule and fictional vignette (service user story) will be provided and used to structure the discussion. You will not be asked to discuss actual service user scenarios.

Will my data be confidential?

The information you provide will be anonymised. The data collected for this study will be stored securely and only the researcher conducting this study and the University supervisors will have access to this data:

- o Audio recordings will be securely stored on an encrypted NHS computer in a password protected P Drive file - archived at the end of data analysis for 10 years and then deleted by the researcher.
- o Hard copies of interview notes will be kept in a locked cabinet – they will be scanned and shredded by the researcher as soon as possible (within 1 working week). Scanned documents will be stored on an encrypted NHS Computer P Drive in a password protected file.
- o Electronic files will be stored on an encrypted NHS Computer P Drive in a password protected file and deleted by the researcher after 10 years.
- o Short term data storage will be via an encrypted memory stick – when in use this will be will be kept in a locked cabinet (by the researcher) – when in transit in a lockable laptop case - and data deleted by the researcher once it has been uploaded to the researcher's encrypted NHS computer P Drive. Upload and deletion will take place within 1 working week, by the researcher.

There are some limits to confidentiality: if what is said in the interview makes me think that you, or someone else, are at significant risk of harm, I will have to break confidentiality and speak to my research supervisor about this. If possible, I will tell you if I have to do this.

What will happen to the results?
The results will be annonymised, summarised and reported in a thesis and may be submitted for publication in an academic or professional journal related to the field of dementia care and treatment.

Are there any risks?
There are no risks anticipated with participating in this study. However, if you experience any distress following participation you are encouraged to inform the researcher and contact the resources described at the end of this sheet.
If you experience any distress during the course of the interview, the researcher will stop the interview, resuming when and if you are comfortable to do so.

Are there any benefits to taking part?
Although you may find participating interesting, there are no direct benefits in taking part. You will be given a letter of thanks which may be helpful as part of your Continuing Professional Development – within your portfolio of evidence.

Who has reviewed the project?
This study has been reviewed by the Faculty of Health and Medicine Research Ethics Committee, and approved by the University Research Ethics Committee at Lancaster University.
It has also been reviewed and endorsed by the NHS Trust ethical approval process.

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Where can I obtain further information about the study if I need it?
If you have any questions about the study, please contact the main researcher:

Email: j.furniaux@lancaster.ac.uk

Or the research supervisor:

Email: s.reilly@lancaster.ac.uk

Complaints
If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact: Professor Steven Jones. Director of Spectrum Centre for   Mental Health Research

Email: s.jones@lancaster.ac.uk
Lancaster University
Lancaster
LA14YD

If you wish to speak to someone outside of the Division of Health Research, you may also contact: Professor Roger Pickup Tel: +44 (0)1524 593746
Associate Dean for Research
Email: r.pickup@lancaster.ac.uk Faculty of Health and
Medicine
(Division of Biomedical and Life
Sciences) Lancaster University
Lancaster LA1 4YG

Thank you for taking the time to read this information sheet.

Resources in the event of distress
Should you feel distressed either as a result of taking part, or in the future, the following resources may be of assistance: Your line manager.
Your professional supervisor.
Staff counselling service via Working Well (Contact the 2gether NHS Trust Human Resources Dept Tel: 01452 894000).

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(Group 2 Interviews)

Title of Study:

<u>Understanding the nature of restrictive intervention management by mental health care workers in an acute mental health setting for people with dementia.</u>

My name is Jan Furniaux and I am conducting this research as a student in the PhD Mental Health programme at Lancaster University, Lancaster, United Kingdom.

What is the study about?

The purpose of this study is to explore the understanding of restrictive intervention management by mental health care workers (non-registered staff and registered health care professionals) involved in the care and treatment of people with dementia.

The study will use interviews to collect data which will take place on Trust premises during the working day - whilst every effort will be made; it is not possible to ensure confidentiality of participation.

<u>You are being asked to participate in an interview .</u>

Why have I been approached?
You have been approached because the study requires information from people who are lead mental health workers involved in the care and treatment of people with dementia. The study will be set within the dementia in-patient unit.

Do I have to take part?
No. It's completely up to you to decide whether or not you take part - participation in this study is voluntary. You are welcome to withdraw from the study at any time up to a week after the interview. Taking clear will have no negative consequences for you.

What will I be asked to do if I take part?
If, after reading the participant information, you agree to take part, you will be asked to complete a consent form.

You will be asked to participate in an interview with the researcher for approximately 60-90 minutes. The interview will take place during work time, at your work place: a convenient time will be agreed with you. The interview will be audio taped. <u>The content of the interview will relate to your</u> <u>experience, as an expert mental health worker, of the strategic and policy context of restrictive intervention</u> <u>management when working with people with dementia</u>. A semi-structured interview schedule will be provided and used to structure the discussion. You will not be asked to discuss actual service user scenarios.

Will my data be confidential?

The information you provide will be anonymised. The data collected for this study will be stored securely and only the researcher conducting this study and my University supervisors will have access to this data:

- o Audio recordings will be securely stored on an encrypted NHS computer in a password protected P Drive file - archived at the end of data analysis for 10 years and then deleted by the researcher.
- o Hard copies of interview notes will be kept in a locked cabinet – they will be scanned and shredded by the researcher as soon as possible (within 1 working week). Scanned documents will be stored on an encrypted NHS Computer P Drive in a password protected file.
- o Electronic files will be stored on an encrypted NHS Computer P Drive in a password protected file and deleted by the researcher after 10 years.
- o Short term data storage will be via an encrypted memory stick – when in use this will be will be kept in a locked cabinet (by the researcher) – when in transit in a lockable laptop case - and data deleted by the researcher once it has been uploaded to the researcher's encrypted NHS computer P Drive. Upload and deletion will take place within 1 working week, by the researcher.

There are some limits to confidentiality: if what is said in the interview makes me think that you, or someone else, are at significant risk of harm, I will have to break confidentiality and speak to my research supervisor about this. If possible, I will tell you if I have to do this.

What will happen to the results?
The results will be annonymised, summarised and reported in a thesis and may be submitted for publication in an academic or professional journal related to the field of dementia care and treatment.

Are there any risks?
There are no risks anticipated with participating in this study. However, if you experience any distress following participation you are encouraged to inform the researcher and contact the resources described at the end of this sheet.
If you experience any distress during the course of the interview, the researcher will stop the interview, resuming when and if you are comfortable to do so.

Are there any benefits to taking part?
Although you may find participating interesting, there are no direct benefits in taking part. You will be given a letter of thanks which may be helpful as part of your Continuing Professional Development – within your portfolio of evidence.

Who has reviewed the project?
This study has been reviewed by the Faculty of Health and Medicine Research Ethics Committee, and approved by the University Research Ethics Committee at Lancaster University. It has also been reviewed and endorsed by the NHS Trust ethical approval process.

Where can I obtain further information about the study if I need it?
If you have any questions about the study, please contact the main researcher:

Email: j.furniaux@lancaster.ac.k Or the research supervisor:

Email: s.reilly@lancaster.ac.uk

Complaints
If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact: Professor Steven Jones. Director of Spectrum Centre for   Mental Health Research

Email: s.jones@lancaster.ac.uk
Lancaster
University
Lancaster
LA14YD

If you wish to speak to someone outside of the Division of Health Research, you may also contact: Professor Roger Pickup Tel: +44 (0)1524 593746
Associate Dean for Research Email:
r.pickup@lancaster.ac.uk Faculty of Health and
Medicine
(Division of Biomedical and Life
Sciences) Lancaster University

Thank you for taking the time to read this information sheet.

Resources in the event of distress
Should you feel distressed either as a result of taking part, or in the future, the following resources may be of assistance: Your Service Director, your professional supervisor. Staff counselling service via Working Well (Contact the NHS Trust Human Resources Dept Tel: 01452 894000).

Appendix 15: Consent Form (Interviews: Groups 1 and 2)

Study Title:

Understanding the nature of restrictive intervention management by mental health care workers in an acute mental health setting for people with dementia.

I am asking if you would like to take part in a research project which aims to explore the understanding of the restrictive interventions by mental health care workers (non-registered staff and registered health care professionals) involved in the care and treatment of people with dementia.

Before you consent to participating in the study I ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the principal investigator, Jan Furniaux.

Please initial box after each statement

I confirm that I have read the information sheet and fully understand what is expected of me within this study

1.   I confirm that I have had the opportunity to ask any

      questions and to have them answered.

2.   I understand that my participation in the interview will be

      audio recorded and then made into an anonymised written

      transcript.

3.   I understand that audio recordings will be kept until the

      research project has been examined.

4.   I understand that my participation is voluntary and that I am

      free to withdraw up to one week after the interview without

      giving any reason and without my employment being

      affected.

V17.2

5. I understand that once my data have been anonymised and incorporated into themes it will not be possible for it to be withdrawn. ☐

6. I understand that the information from my interview will be pooled with other participants' responses, anonymised and may be published. ☐

7. I consent to information and quotations from my being used in reports, conferences and training events. ☐

8. I understand that any information I give will remain strictly confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the principal investigator may need to share this information with her research supervisor. ☐

9. I consent to Lancaster University keeping scanned transcriptions for 10 years after the study has finished.

10. I consent to take part in the above study. ☐

Name of Participant_____**Signature**_____**Date** _____

Name of Researcher_____**Signature**_____**Date** _____

If you would like to participate, please sign the consent form and return to me in the addressed envelope provided (Trust internal mail).

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Appendix 16: Participant demographic sheet

Please answer the questions below – if you would prefer not to answer, please leave the boxes blank.

Study phase involved (to be completed by the researcher)

Interview Group 1 ☐

Interview Group 2 ☐

Participant ID (to be completed by the researcher): ☐

Participant demographic details:

Age ☐

Gender: Male ☐ Female ☐

Ethnicity ☐

White

1 = White British
2 = White Irish
3 = Gypsy or Irish traveller
4 = White Other

Asian and Asian British

9 = Indian
10 = Pakistani
11 = Bangladeshi
12 = Chinese
13 = Any other Asian background

Mixed and multiple ethnic groups British

5 = White and black Caribbean
6 = White and black African
7 =White and black Asian

Black and African and Caribbean and Black

14 = African
15 = Caribbean
16 = Any other black and African and Caribbean background

8 = Any other mixed and multiple
Other Ethnic Groups: 17 = Arab; 18 = Any other ethnic group – please specify: 99 = Not recorded.

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