PERCEPTIONS TOWARD A RESTRAINT-FREE PRACTICE: A CASE STUDY

by

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Abstract

The importance of reducing the use of psychiatric-mental health mechanical restraints has been the focus of clinical nursing practice. A hospital with two psychiatric-mental health units has demonstrated a sustained success related to reducing mechanical restraints. In this qualitative case study, nurses were interviewed to understand how the reduction of mechanical restraints on the psychiatric-mental health units impacts the practice culture and the perception of the psychiatric nurses toward a mechanical restraint-free practice. This study provided new knowledge related to evidence from the psychiatric-mental health nursing practice, themes of barriers, and facilitators toward a restraint-free practice. The participants describe the complexity of the nursing role, how the decision to use restraints is complex, the first hand experience of the nurse who was a part of the leather restraint process, that moving the restraints off the units did not make a difference, that the removal of the restraints from the building was not supported by the nurses. The barrier themes are current practice, medication, and patient acuity or behavior. The facilitator themes are philosophy, CPI implementation, practice or culture change, and medication. This is an innovative study on a restraint-free practice. The recommendations stem from the new information obtained from the evidence and themes and include further inquiry into the passion of nurses to avoid restraint, understanding personal style as well as interaction and bias, environmental alterations, and theme-based recommendations. The evidence and themes provide nursing and nursing leadership knowledge for application to other facilities that are considering a restraint-free environment.

Keywords: Restraint-Free, Reduction, Restraints, Mechanical Restraints, Restraints, Restraint-Free Practice

Dedication

Family comes in many forms. I have been fortunate enough to experience several support systems that I can call family. First, I dedicate this to my husband and daughter, who have been passionate, supportive, and excited about my journey toward this degree. Next thank you to my parents. My mother taught me to persevere. My dad taught me to reach (may he rest in peace). To my sister who is always there to listen. To my sister-friends (and their husbands) that lifted me up and supported me. Finally, I want to thank my cohort-friends and colleagues who went on this journey and succeeded with me. Thank you to all of you!

Acknowledgment

My dissertation committee has been generous in their time and knowledge. I appreciate all that they have shared and taught. The hospital where I work, especially my Directors and the Chief Nursing Officer have provided unending support. I especially want to thank the participants. I thank you all!

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Chapter 1

This chapter addresses the phenomenon under study. Beginning with the problem statement, the first chapter presents the background and rationale, as well as the case for the case study or unit of analysis, scope, and purpose of the study. In addition, the study's nature, research question, terminology, assumptions, delimitations, limitations, significance and contribution, and are discussed later in the chapter.

Background and Rationale

The Centers for Medicare and Medicaid Service (CMS) required that hospitals report all restraint-related deaths (Abrahamsen, 2001; H.R., 2006; Ross, 2001). A federal report (H.R., 2006) during the period of August 2, 1999, to December 31, 2004, noted there were 104 behavioral health-related restraint deaths. In 1999, mechanical restraints and adverse outcomes caught the attention of individuals in the political and public arenas (Mohr, Petti, & Mohr, 2003). Over a decade later, Keltner and Lillie (2011) indicated that the United States Food and Drug Administration (FDA) estimated at least 100 deaths per annum from restraints in all healthcare settings. The reported 100 deaths included medical and psychiatric patients; the specific differences between the medical and psychiatric restraint statistics were not readily available. The published statistics indicate the importance of restraint reduction and elimination of restraint use.

The focus on restraint reduction by the governing agencies has led to a pivotal change in psychiatric-mental health nursing practice based on documented injuries and deaths incurred at inpatient psychiatric-mental health settings. The debate surrounding the use of psychiatric-mental health mechanical restraints propelled governing agencies such as the Centers for Medicaid and Medicare and the Joint Commission to adopt stricter regulations and efforts toward

the goal of reduction and elimination of mechanical restraints in psychiatric-mental health settings because of a range of adverse outcomes that have occurred during mechanical restraint use (Lebel, 2007). The standard adverse outcomes have included injury to nursing staff, other healthcare providers and patients (Grigg, 2006). Yet, mechanical restraints continue to be used despite the numerous negative outcomes and regulatory changes (Sivak, 2012).

The American Psychiatric Nurses Association ([APNA], 2007a) published a members' position statement that called for the future elimination of mechanical restraints, while also focusing on restraint prevention. After the APNA's 2007 position statement was released, psychiatric facilities reduced their use of such restraints. According to McCloughen (2009), however, the need for the reduction and possible elimination of restraint continues for psychiatric inpatient settings. Healthcare workers have responded to the call for mechanical restraint reduction in various ways. For example, nurses have been educated about the utilization of other alternatives to implement before the use mechanical restraints, such as verbal de-escalation or distraction therapy (CPI, 2012).

Changing restraint protocol for inpatients has been difficult for the culture of psychiatric nursing. Curran (2007) discovered several barriers while researching the concept of restraint reduction in psychiatric institutions. The barriers revealed by Curran included lack of awareness of changes in restraint philosophy, concerns for nurses' own safety, lack of nursing knowledge about and use of alternative de-escalation skills, fear of disrupting the routine psychiatric-mental health patient environment. Using a variety of de-escalation methods, stopping the momentum or reversing the decision to place the patient in restraints, nurses' resistance to change, and peer pressures from other nurses were other barriers noted by Curran (2007). Despite these barriers Curran noted some nurses' efforts to make some changes toward restraint reduction were still

successful, resulting in a significant reduction in the use of mechanical restraints for some psychiatric patients.

The barriers regarding restraint reduction can be addressed by psychiatric-mental health facilities through a change in the culture of the practice environment. Specific steps for a culture change in the literature for psychiatric nursing include the addition of qualified and adequate number of staff, the orientation training of staff, active therapeutic (individual and group therapy) and pharmacologic treatment of patients, better risk assessment of patients, individualized treatment-based planning, medications available to at-risk patients, stronger patient-centered care, improved data collection and analysis, and institutional policy changes (Curie, 2005). LeBel, (2007) described that by implementing restraint reduction practices that some psychiatric-mental health units were so successful that some inpatient psychiatric units now have minimal restraint usage, such as the hospital psychiatric unit that is the focus of this current case study (LeBel, 2007).

The research study is a case study analysis that explored the staff nurses' perceptions of what led to successful restraint reduction in a Midwestern psychiatric facility and what it means for complete mechanical restraint removal from hospitals. Through such exploration of a Midwestern United States' hospital program's success in implementing restraint reduction by researching the perceptions of psychiatric nurses, the study focus explored the areas of facilitation that the nurses believe assisted the decrease in restraint use, and identify potential barriers for complete removal of mechanical restraints from the psychiatric units. The term facilitators refers to the concepts that were identified in this case study analysis found to enable the removal of mechanical restraints. The concepts identified in this case study analysis to prevent the removal of mechanical restraints would be referred to as barriers.

Problem Statement

The study focuses on the psychiatric-mental-health field of nursing; in particular, psychiatric nurses' use of specific intervention methods of restraint for inpatients. The use of mechanical restraints (leather) in an acute inpatient psychiatric setting is an intervention method that has been available to nurses for decades. In the field of psychiatric nursing, the use of mechanical restraints has been and continues to be a longstanding controversy related to the injuries of nurses and other healthcare providers, as well as to the patients' injuries incurred with mechanical restraints in the clinical field of psychiatric-mental health nursing.

Scope of the Study

The research focused on the perceptions of nurses who currently have mechanical restraints available for use as an intervention approach in an inpatient psychiatric hospital facility. The study identified themes and patterns related to the perceptions of bedside nurses, while focusing on the creation of a mechanical restraint-free environment. Through exploring theme identification, the researcher became aware of the facilitators and barriers that exist in the intervention of a mechanical restraint-free environment. Additionally, through the researcher's exploration of inpatient psychiatric nurses' perceptions regarding the facilitators and barriers that exist in mechanical restraint-free environments, nurse leaders can identify restraint reduction interventions from the bedside nurses' experiences and perceptions ascertained and analyzed in the current study. Such discovery will assist the field of psychiatric nursing leadership in implementing future measures for successful and permanent removal of mechanical restraints.

Purpose of the Study

Individuals who seek hospitalization related to acute or chronic mental health issues have the legal right to dignity, privacy, and autonomy; therefore, such individuals have protections

related to the unnecessary use of restraints (Anonymous, 2001; Dean, 2007; Moylan, 2009b). In the past, the use of restraints on psychiatric patients became a public concern, particularly regarding the traumatic experiences endured by patients and staff members. Patient experiences regarding restraints have been predominantly negative, including documented physical injuries, emotional trauma, and re-traumatization (Dahan, Levi, Gehrbalk, Melamend, & Bleich, 2007; Grigg, 2006; Huckshorn, 2006). Retraumatization is when a patient has an experience that adds to a previous trauma, creating a culmination of emotional injury. For example, a patient who has a history of a forced sexual assault and is later mechanically restrained, may experience a flashback to the feelings he or she had during the assault. The patients' traumatic and harmful experiences warrant increased research with the goal of understanding and eliminating them (Frueh et al., 2005).

Nursing staff also has reported mixed feelings about the use of such restraints, including personal conflict and guilt (Gelkopf et al., 2009; Roffe, Gelkopf, Behrbalk, Melamed, & Bleich, 2007; Saarnio & Isola, 2010). The independent nursing decision to use restraint on a psychiatric patient leads to distress for the nurse, as he or she negotiates the struggle between being therapeutic and maintaining a restraint-free facility with the balance of stabilizing the milieu or the environment of the psychiatric-mental health unit (Larue, Dumais, Ahern, Bernheim, & Mailhot, 2009).

Nature of the Study

A review of the literature supported the initial observation that the consistent use of restraint reduction interventions was a seldom-researched psychiatric-mental health nursing intervention. There is a consistent lack of evidence or discussion for pre-mechanical restraint interventions. In a retrospective chart audit, Dumais, Larue, Drapeau, Menard, and Giguere

(2011) found that the circumstances surrounding restraint intervention were not well documented. The study contributed to the knowledge of potential facilitators and barriers by presenting the restraint reduction techniques that each nurse experienced in the context of an ideology of having a restraint-free environment. The current case study provided the basis for future research examining protocols or interventions for hospitals in converting to mechanical restraint-free nursing practice.

The nature of the research evolved over the course of the study (Polit & Beck, 2004). The central goal of this study was to determine the perceptions of psychiatric nurses related to the possibility of adopting a restraint-free environment based on these nurses' experiences with restraint reduction. Themes were identified from the perceptions of bedside psychiatric nurses to learn the specifics of restraint reduction for further evaluation so that a restraint-free environment can be considered for implementation at other facilities. The themes and patterns that arose from the nurses' experiences in this study addressed how and why the unit was successful in reducing the use of restraints, and how such successful perceptions and ideas may lead to complete removal of restraints in nursing practice. To answer questions of how and why a qualitative design is appropriate. In the qualitative study, the research will focus on extracting perceptions from nursing staff members on specific units within a specified hospital.

Research Question and Aim

The central research question for this study overarches the study problem of continued mechanical restraint use despite untoward outcomes and regulatory changes, and the purpose examined facilitators for restraint reduction at the identifed psychiatric-mental health units. The main research question is: How has the reduction of mechanical restraints on the psychiatric-mental health units impacted the practice culture? An area of additional inquiry is the sub

question: What is the perception of the psychiatric nurses toward a mechanical restraint-free practice with acute psychiatric inpatients? The aim or intention of this study was to gather the perceptions of psychiatric nurses related to their successes in reducing restraint use and to have a discussion of past experiences to understand perceptions on the idea of futuristically moving toward a restraint-free unit. The research question and sub question incorporate the meaning of concepts and experiences from the nurse's perspective allowing the research aim to flow logically from the research topic and the researcher to gain a deeper understanding of how to implement a mechanical restraint–free environment. By addressing the research question and aim, there was a contribution to the knowledge and science of nursing.

Concepts

The use of thick descriptions (Yin, 2011) documents a common language for the study. The key concepts utilized throughout the dissertation are included to establish a common study language and are (a) nurse is a registered nurse (RN) that works in a psychiatric unit in a formal capacity. The nurse has at least 1 year of direct psychiatric-mental health nursing experience at the unit under study, and is currently practicing in the psychiatric unit at the focus facility; (b) restraint described as mechanical leather restraints used for the restriction of freedom of movement to prevent harm to oneself or others in a horizontal position. The restraint attaches to a restraint-ready bed. This study does not focus on cloth restraint, physical holding, seclusion, or chemical restraint. The focus is on the controversial leather restraint. Cloth restraints are a medical restraint not used within the psychiatric-mental health units. Physical holding is an acceptable method for use during a forced medication intervention. In addition, the unit does not use chemical restraints; (c) restraint-free is a patient care decision that a psychiatric unit no longer contains leather restraints for use as an intervention; (d) trend is a movement toward

something new or different that is part of practice changes; (e) perception described as the interpretation which comes from an individual's past experience and interactions, and projected toward an upcoming or past event; and (f) practice culture is the way nurses in the psychiatric-mental health specialty provide care to the patients. This encompasses nurses' attitudes and behavior.

Unit of Analysis

The sustained reduction in the use of psychiatric-mental health mechanical restraint at a midwestern hospital has made it a focus of interest to study. There are two psychiatric-mental health inpatient units within the hospital considered to be an exemplar site, as the restraint events have reduced significantly in the past 10 years. The number of leather restraint episodes in the past year has been one. The setting of the behavioral health services includes two units, adult and youth. The youth unit admits children from 13 to 18 years of age and has a capacity of 15. The adult unit admits 18 years of age and has a capacity of 30.

The case study is bound to interviewing the clinical nursing staff on the two psychiatric-mental health units. It is the perceptions of the nurses who provided the data for analysis in exploring the research question: How has the reduction of mechanical restraints on the psychiatric-mental health units impacted the practice culture? A sub-question was: What is the perception of the psychiatric nurses toward a mechanical restraint-free practice with acute psychiatric inpatients? Both units are considered the case study unit of analysis, as the practice of the nurses is the same when it comes to restraint reduction and usage. The nurses float or work between both units as the census of the inpatient population fluctuates. The nurses have a primary psychiatric-mental health unit as their official place of employment. All nurses have

been cross-trained to transfer to either the adult or the youth units during times of need as unit population or census increases or decreases.

Assumptions

The first assumption is that all psychiatric-mental health nurses have mechanical restraints available as an intervention. The second is that the psychiatric-mental health nurses would be able to articulate their perceptions of a mechanical restraint process, whether or not they have utilized mechanical restraints as an intervention. The last assumption is that the hospital maintains the current ideology of reducing mechanical restraints throughout the duration of the study. Foreshadowed issues or theories how the organization can influence the findings include the maintenance of the current ideology of reducing mechanical restraints throughout the duration of the study (Simons, 2009).

Delimitation

A delimitation is a boundary that has been self-imposed by the researcher which will limit the scope of this study (Lunenburg & Irby, 2008). The boundary that was set for this study included limiting the population to psychiatric-mental health nurses. There are many other team members who work at the psychiatric-mental health units, including recovery specialists, therapists, support staff, recreational therapist, and Chaplain. The importance of this delimitation is so the researcher could gain an understanding of the perceptions of psychiatric-mental health nurses to gain new empirical nursing knowledge.

Limitations

Limitations are the potential weaknesses that are out of the control of the researcher (Simons, 2009). The identified limitations for this study include (a) administration of the psychiatric-mental health units support for a restraint-free unit is a limitation to the study. This

can affect the staff nurses' behavior and beliefs. (b) case study is a comprehensive review of the unit of analysis or the psychiatric-mental health units. Generalizabilty or transferability can be limited to units with the same descriptors; (c) case study method is a subjective method; (d) data that includes self-disclosed information can be skewed by many factors, including memory, honesty, motivation, and positive or negative reaction to the researcher; (e) the researcher is a employee of the psychiatric-mental health units and could be viewed as having an opinion that is different than the nurse; and (f) the researcher is a colleague of the participants and has interacted with the psychiatric-mental health nurses, so the interviews may be viewed as social conversation by the participants.

Significance and Contribution

The potential impact of the current study on nursing education, leadership and practice includes increased knowledge that can inform policy, theory, and practice. An evaluation of psychiatric nurses' perceptions of restraint reduction and a restraint-free psychiatric facility led to the facilitation and identification of the barrier details that may be related to the permanent removal of such restraints from psychiatric units. The exploration of the psychiatric nurses' perceptions informed psychiatric-mental health nursing science. Through the research, the perspectives of bedside psychiatric nurses were organized into themes, identifying the ideology behind removing and not removing restraints from psychiatric units. The current study contributes to scholarly and empirical knowledge by identifying facilitators and barriers towards restraint-free units and exploring the details of decision-making and nurses' perceptions.

There were gaps in the existing literature related to restraint-free psychiatric units. McCloughen (2009) indicated that well-planned restraint reduction programs seldom lead to restraint elimination. Many psychiatric units experience the same success of restraint reduction

as this study's unit. The perceptions of the nurses in this study bring the restraint-free intervention forward as an empirical focus. Barton, Johnson, and Price (2009) describe a unit improvement project that led an inpatient behavioral health unit to become restraint-free. The factors attributed to a restraint-free environment include staff education and the adoption of the Mental Health Recovery Model (Barton et al., 2009; Huckshorn, 2004; National Health Service, 2008). The Mental Health Recovery model includes guiding principles which instill hope, individualize the path to recovery, holistic approach, support from multilevel sources, cultural relevance, addresses trauma experienced in the past and the potential for further trauma, evaluates responsibilities and strengths, and which is is based on respect (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012). Many of the studies included in the review were related to restraint reduction and concluded with a need for further research on the topic of restraint reduction and elimination including additional information on the interventions chosen, the correlation between specific diagnosis and ages, and the development of other alternatives (Bak, Brandt-Christensen, Sestoft, & Zoffmann, 2012; Chukwujekwu & Stanley, 2011; Delaney, 2006; Steinert et al., 2010; Tompsett, Domoff, & Boxer, 2011).

In a review of psychiatric nursing intervention studies, it was found that there is a need for improved research dissemination, rigorous testing of the psychiatric nursing interventions, and more programs focused on effective nursing interventions, especially globally and across lifespans (Zauszniewski, Suresky, Bekhet, & Kidd, 2007). Psychiatric nurses have the opportunity to "promote, develop, and implement recovery-oriented care across the lifespan in all aspects of psychiatric nursing, from the community to facility-based settings" in uncharted areas of nursing science (Moller & McLoughlin, 2013, p. 115). While previous studies have focused on successful restraint reduction, the current study focused on nurses' perceptions to

promote an increased awareness of the facilitators and barriers for psychiatric nursing leaders choosing to follow the trend of restraint-free psychiatric units, thus adding new knowledge to the science of nursing. After the completion of a qualitative study to discover the de-escalation skills of psychiatric-mental health nurses, Delaney and Johnson (2006) identified, several themes in their study of the reduction of violence, and suggested continued inquiry to identify critical nursing interventions and how to develop these skills. Violence is a "complex phenomenon" that requires further consideration and research (Sailas & Wahlbeck, 2005). The study not only adds to the existing violence literature, but also exploration of the facilitators and barriers toward the elimination of mechanical restraints in inpatient psychiatric units.

Nurses, as a part of a code of ethics, consider the safest practices for the patient, themselves, and others. Injuries and death are associated with the use of restraints (Morrison, 2013), and nursing practice is ever evolving. The themes from the qualitative case study analysis enhance understanding of improving the safety with a patient in behavioral crisis. The use of the themes assists nurses in understanding the facilitators and barriers related to the restraint reduction and restraint-free environment. This can increase safety by decreasing injuries and preventing death through the thoughtful consideration of the analyzed themes from psychiatric nurses' perceptions in this study. Next, the application of the successful practices can be implemented, and the barriers can be understood to further improve restraint reduction and elimination.

Theoretical Framework

The theoretical framework of a study provides a logical structure for the linking of the findings to the body of nursing knowledge. The theoretical framework for this case study is drawn from three distinct nursing models: Peplau's psychodynamic nursing (also known as

interpersonal relations in nursing), Watson's human caring, and Roys' adaptation theory (See Figure 1). Peplau's theory has three phases: orientation, working, and termination (Peplau, 1997). The rationale for the use of Peplau's theory on the research topic of perceptions of a restraint-free environment is to guide the relationships and interactions between the interviewed nurses and the researcher, as well as the analysis of data. While grounded in Peplau's three phases of psychodynamic nursing, the current study framework included elements of Watson's (2010) human caring and Roy's adaptation theory. The specific element of human caring related to the research is the caring moments, which strengthened the interactions between the researcher and the participant. Roy's systems model added the characteristic of fluid relationships and processes to the psychodynamic nursing theory. Both Watson's caring moments and Roy's explanation of system adaptation surrounded and influenced the relationship between the researcher and the participant while adding depth to the research study during collection and analysis of the data.

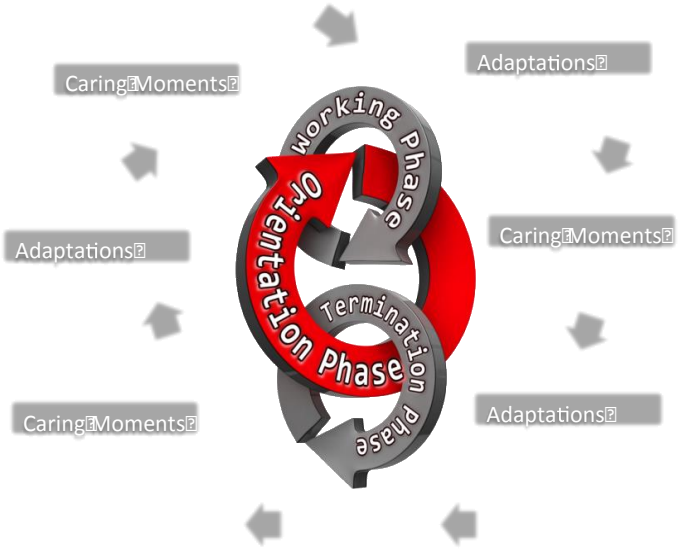

Figure 1. Theoretical Peplau-Watson-Roy Framework

Introduction Summary

Chapter 1 provided a foundation for the remainder of the study. The explanation of the problem statement, background and rationale, purpose, significance and contribution, nature, and the questions/aims of the study highlighted the importance of this study. The definition of the dissertation concepts set up the common language for use throughout the study. Lastly, the theoretical framework provides the academic scaffold for the current study.

Chapter 2

Initial Literature Review

The purpose of this qualitative exploratory case study was to understand the experiences and perceptions of psychiatric nurses related to the successes of restraint reduction and toward a mechanical restraint-free practice on an inpatient psychiatric unit. The idea of restraint-free psychiatric facilities is a relatively new phenomenon. Through the exploratory case study approach, the experiences and perceptions of the psychiatric nurses provide an understanding of the restraint-free trend, and allow nurse leaders to determine readiness to change to a restraint-free psychiatric unit by evaluating the bedside nurse perceptions of facilitators and barriers (Burns & Grove, 2011). Nurse scholars, leaders, and practitioners can use the findings from this study to improve care, policies, and set higher standards in facilities and the practice of nursing

This chapter provides a historical overview of psychiatric nursing and restraint usage, synthesizes current knowledge about the practice of restraint usage, reasons for leather restraints, alternative for leather restraints, nursing culture, patient view, nursing view, and leadership view. The study methodology and design details are outlined, followed by an explanation of the theoretical framework; these components further define the empirical basis of the study specifics. Each piece of literature is analyzed through the viewpoint of coverage, synthesis, method, significance, and rhetoric. These viewpoints guide the review of the literature by an in-depth analysis of each study or article for credibility and applicability to this study's literature.

Traditionally, the literature review for a qualitative study is selective. The selective search leads to an initial understanding of a research topic (Yin, 2011). This initial literature review assisted in discovering concepts for the direction and execution of the study (Burns & Grove, 2011). The completion of this comprehensive literature review followed the tradition of

the university. Reviewing the literature is an ongoing process for this qualitative study beginning with a review of the current literature on the phenomenon (Burns & Grove, 2011). The literature review process expanded to include the discovered themes as well as the evaluation of other studies published during the data collection and analysis phase of the study (Burns & Grove, 2011). This initial literature review allowed for an explanation of the relevant history and current knowledge of the research topic, question, and purpose related to a restraint-free environment, method and design, and theoretical framework.

Searches, Journal Articles, Books, and Research Documents

A number of journal articles, books, and research documents were searched using many combinations of the key words from the dissertation title and multiple databases (See Table 1). BOOLEAN searches were employed to assist in narrowing the results. The final literature review was limited to sources translated into the English language. Inclusion criteria for the reviewed literature were consistent with the key concepts of the research topic. Only peer-reviewed, relevant, and scholarly sources were included in the literature selection for critique, analysis, and synthesis. Exclusion criteria for the reviewed literature included titles that were non-scholarly, newspaper articles, or non-credible websites. During the literature search, germinal articles were included that documented the need for restraint reduction and transition from the frequent use of restraints to successful restraint reduction concepts. The sources that met the search criteria included peer-reviewed journal articles, professional opinions, books, and other publications.

Table 1. Literature Search Results

Database	Keywords with Boolean Searches	Results
CINAHL Complete	Restraint-free, psychiatric, psychiatric nurses, aggression, aggression management, restraint, restraint of patient(s), mental health, no restraint, reduction of restraint, nurse perception, and elimination of restraint	1,137
Nursing@OVID	Restraint-free, psychiatric, psychiatric nurses, aggression, aggression management, restraint, restraint of patient(s), mental health, no restraint, reduction of restraint, nurse perception, and elimination of restraint	650
EBSCOhost	Restraint-free, psychiatric, psychiatric nurses, aggression, aggression management, restraint, restraint of patient(s), mental health, no restraint, reduction of restraint, nurse perception, and elimination of restraint	149,720
Google Scholar	Restraint-free, psychiatric, psychiatric nurses, aggression, aggression management, restraint, restraint of patient(s), mental health, no restraint, reduction of restraint, nurse perception, and elimination of restraint	9,316,000
PubMed	Restraint-free, psychiatric, psychiatric nurses, aggression, aggression management, restraint, restraint of patient(s), mental health, no restraint, reduction of restraint, nurse perception, and elimination of restraint	843,314
ProQuest	Restraint-free, psychiatric, psychiatric nurses, aggression, aggression management, restraint, restraint of patient(s), mental health, no restraint, reduction of restraint, nurse perception, and elimination of restraint	973,842

Note. Boolean searches include the use of *AND* and *OR*

The literature review of the final resources used in the development of the research study included careful consideration of the criteria from the School of Advanced Studies at the University of Phoenix (2011) Dissertation Rating Scale: Coverage, Synthesis, Method, Significance and Rhetoric. Each of the references was critiqued using these criteria to ensure credible sources for the empirical evidence.

Coverage. The search criteria and scope were well defined and justified. The criteria for inclusion and exclusion was listed and justified with most of the research studies. In addition, each article was supported by relevant, scholarly, and peer-reviewed sources.

Synthesis. Each study included an extensive literature review. The appropriate summation, analysis, and synthesis were noted with each study. The synthesis evolved from the integration of the researcher's thoughts from the existing literature.

Method. Each of the studies was clearly defined and documented the significance of the research problem or focus. The description of the literature in each study did not always include gaps or opportunities. Most of the authors included a description regarding the limits of their own research.

Significance. The significance of each study or article was clearly documented. The documentation of the implications was highlighted during the literature review when appropriate. Many of the studies or articles did not include a discussion of the shortcomings or ambiguities in the related literature.

Rhetoric. All the sources came from peer-reviewed and scientific journals, and therefore, most utilized APA style. The writing styles varied, but the authors were coherent. Documentation of the study or article recommendations included references to the literature that supported the author's conclusions.

Historical Overview of Psychiatric Nursing

Psychiatric-mental health nursing has existed for decades. In the late 1980s, nursing leaders recognized that the role of the registered nurse practicing in the psychiatric setting needed to adapt to the current treatment environments. Nurses became more involved with the care of the patient through primary nursing. Consequently, a new model for psychiatric nursing practice was developed involving three tools that complemented the traditional emphasis on the nurse-patient relationship (Keltner, Schwecke, & Bostrom, 2007). The primary tools for psychiatric mental health nurses include themselves, medications, and the environment (Keltner,

et al., 2007). The nurse is an integral part of assisting patients in becoming healthy and productive individuals. Psychiatric mental health nursing utilizes four objectives to meet the goals of mental health: promotion, prevention, treatment, and restoration of health (Holoday Worrett, 2008). The majority of inpatient nursing practices tends to focus on the last two tools (Holoday Worrett, 2008). Restraints fit into the third tool, as leather restraints have been used as an intervention in the treatment of psychiatric patients.

The use of restraints is now a less desired treatment intervention within the inpatient setting to assist in stabilizing patients for optimal mental health (Curtis & Capp, 2003). As an adjunct intervention, restraint usage for psychiatric inpatients can become problematic, as there are high-risk, unpredictable, and deleterious occurrences (Lewis, Taylor, & Parks, 2009). Psychiatric nursing is a complex specialization. Nurses rely on assessment skills, the observation of the milieu, and critical thinking to determine the early identification of escalating behaviors (Jayaram, Samuels, & Konrad, 2012; O'Brien & Cole, 2004). Through the early identification of escalating behaviors, individualized nursing interventions assist patients in de-escalating and avoiding the use of restraint (D'Orio, Purselle, Stevens, & Garlow, 2004; Irwin, 2006). It is through a combination of an aggression risk assessment, a nursing assessment, and intuition that a more accurate prediction of aggression occurs (Phillips, Stargatt, & Fisher, 2011; Ogloff & Daffern, 2006).

However, if the escalation of behavior is not caught early or interventions fail, restraints may be implemented. Nurses are the first professional to make the decision about the application of the restraint (Lai, 2007; Larue et al., 2009; Roffe et al., 2007; Ryan & Bowers, 2005). The right for patient's is to be free of restraint (Centers for Medicare and Medicaid Services & Department of Health and Human Services [CMS & DHHS], 2011). Several exceptions allow

the violation of this right. For example, if the patient threatens harm to themselves or other persons, the healthcare facility has a duty to protect the patient from him or herself or to protect others (Werth, Welfel, & Benjamin, 2009). Asssessment, observation, and critical thinking were used to make these unplanned decisions by the bedside nurse including the initiation of restraints (Larue et al., 2009).

The existing literature reflects the lack of documentation for a restraint-free practice in the context of an inpatient psychiatric setting. Since restraint reduction and the restraint-free trend are focused interventions of the psychiatric–mental health nurse, the experiences of those closest to this intervention need to be understood to ensure the delivery of optimal healthcare to patients. Once the restraint-free perceptions are understood, leaders may be able to standardize nursing practice and gain insight into the barriers and facilitating behaviors of restraint-free practice. Understanding facilitators and barriers for accepting and using a restraint-free practice can optimize care for the future patients and practice for nurses. Interactional leadership provides consistency for nursing practice. Those who apply an interactional leadership approach listen to the individuals affected by the change or practice and understand the meaning.

Historical Overview of Restraint Usage

Aggression during an acute hospitalization has been challenging and problematic for nursing staff for some time (Chukwujekwu & Stanley, 2011; Cookson, Daffern, & Foley, 2012). Some aggression occurs without provocation and the consequences are extensive (Chukwujekwu & Stanley, 2011). Hostile behavior has been documented in forensic psychiatric units (Schreiner, Crafton, & Sevin, 2004; Tema, Poggenpoel, & Myburgh, 2011). The multiple contributing factors to aggression and violence are the patient's mental status, patient's admission conditions, staffing shortages, lack of team support, and lack of a comprehensive and structured orientation

for new staff members (Bimenyimana, Poggenpoel, Myburgh, & Van Niekerk, 2009). Restraints have had a significant presence in psychiatric intervention since the Middle Ages (Erb, 2008; Knight, 2011). The uses of biologic treatments such as psychosurgery, sterilization, insulin shock therapy, and physiotherapy (wet packs, cold sheets, and hot and cold water), and restraint or seclusion were the only form of treatment until psychotropic medications were introduced in the 1950s (Knight, 2011; Shives, 2008). Even after the widespread use of psychotropic medication, the use of restraint has persisted. The purpose has been for the control of aggressive or other behaviors that are difficult to manage (Keltner & Lillie, 2011). The use of restraints is not for the purpose of discipline, staff convenience, staffing, or active treatment (Huckshorn, 2006). Acute escalating behaviors associated with a psychiatric inpatient stay include paranoia, restlessness, agitation, hallucinations, and thought disorders. These behaviors contribute to suicidal or homicidal behavior depending on the patient's view of the clinical situation (Knight, 2011).

The use of leather restraints is a psychiatric intervention that has been controversial and troubling due to conflicting perspectives (Barton et al., 2009; Mohr & Anderson, 2001; Van Doeselaar, Sleegers, & Hutschemackers, 2008). The use of a restraint is a complex intervention that "is simultaneously a violent" and intimate experience for the patient (Hejtmanek, 2010, p. 668). The use of the terms control and restraint can be traced back to the 1980s, specifically to prison service, which may contribute to the controversial perspectives (Paterson et al., 2009). Restraint use is for the prevention of self-harm or harm to others (APNA, 2007b; Gelkopf et al., 2009; Stewart, Bowers, Simpson, Ryan, & Tziggili, 2009). The conflicting perspectives are that restraint is necessary and/or therapeutic, or that restraint use is a violation of human rights and used as punishment and control by health care staff (Moran et al., 2009).

The perspective of therapeutic use, the benefit of restraints, or long-term effectiveness is not consistent or strongly supported by the scientific community (Ferlegen & Morrison, 2013; Holstead, Lamond, Dalton, Horne, & Crick, 2010; Paterson & Duxbury, 2007; Perlman et al., 2013; Mohr & Anderson, 2001; Moran et al., 2009; Morrison et al., 2000; Stewart, Van der Merwe, Bowers, Simpson, & Jones, 2010; Terpstra, Terpstra, Pettee, & Hunter, 2001). Restraints do not positively change behavior (Ferlegen & Morrison, 2013). The use of restraints increases negative behavior (Ferlegen & Morrison, 2013). An attempt to use less restrictive measures than restraint when there is clinical doubt does not increase harm or represent coercion for patients 1further documentation of the effectiveness of restraint, as well as continued research for the reliability and validity of a tool that can be used to focus on quality improvement (Perlman et al., 2013). The use of restraints is a traumatic event for both the patient and staff (Ferlegen & Morrison, 2013; Huckshorn, 2006). Patients have reported negative effects associated with the use of restraints, including anger, fear, bitterness, and a negative view of therapeutic staff (Knight, 2011). These effects of a restraint episode are long lasting and leave psychological scars (Ferlegen & Morrison, 2013).

The violation of human rights perspective has been of concern by all individuals involved with restraint events. Mohr et al. (2003) supported the idea of restraint as a violation of rights because not all episodes of restraint have been related to an imminent self-harm or harm to another individual. The use of restraints that conflict with the ethical principles of beneficence requires serious consideration before this intervention occurs (Colaizzi, 2005). Education and awareness of the ethical issue of patient rights maintenance can be effective in restraint reduction (Dahan et al., 2007). Nurses need to weigh the restraint decision with the ethical right that the patient is to be free of restraint (CMS & DHHS, 2011). In a qualitative metasynthesis the

findings include that nurses make the complex decision on the use of restraints focusing on safety (Goethals, De Casterle, & Gastmans, 2011). The options considered during the decision-making of the need for restraints are balanced with the ethical responsibility of the nurses (Goethals et al., 2011). Nurse-related factors can be barriers to an ethically and morally balanced decision about the use of restraints (Goethals et al., 2011). Examples of these factors include resources, family preferences, physician orders, lack of processing time, and the environment (Goethals et al., 2011). The decision is also based on rational needs as well as the team's perception of the patient and the characteristics of the staff members and therapeutic environment (Larue et al., 2009). Restraint use can become quickly problematic as there are high-risk, unpredictable, and deleterious outcomes (Lewis et al, 2009).

The use of restraints for safety is a myth, and the reality is that restraints are used primarily to control loud, disruptive, and non-compliant behavior (Davis, Magnus, Pichardo, Tellez, & Gantsweg, 2013). Traditionally, restraints have been one of the first interventions automatically utilized. It has been found that power struggles between the staff members or the staff and the patient lead to restraining the patient (Ferlegen & Morrison, 2013). Ferlegen and Morrison (2013) found that the decision to use restraint is typically arbitrary and avoidable. Cultural bias, negative role perceptions, perceptions of the patient aggression, emotional reactions, and biased attitudes of the staff can be understood and altered to avoid the triggering of behaviors that initiate restraint usage (De Benedictis et al., 2011; Marangos-Frost & Wells, 2000).

Despite these perspectives, restraints are controversial and dangerous, causing injury to patients and staff, as well as death (Barton et al., 2009; Huckshorn, 2004; Lewis et al., 2009; Mohr & Anderson, 2001; Terpstra et al., 2001). Patient injuries have included asphyxia,

aspiration, cardiac events, fractures, dislocations, and repeated experience of trauma with resulting psychological distress (Morrison, 2013; Morrison et al., 2000). According to Southcott (2007) the use of restraint has been effective for some intensive psychiatric-mental health patient situations.

During the 1970s, ex-patients collaborated and questioned the medical model of practice for mental illness and protested harmful treatments (Bluebird, 2004). In 1996, Charles Curie began a restraint reduction initiative in Pennsylvania (Huckshorn, 2004). Rocky Bennett in 1998 died from a prone lying restraint episode for 25 minutes, the questions surrounding this death were related to excessive force (Kenny, 2005). In 1998, a series of investigative reports in the Hartford Courant brought to the social, cultural, and political arenas the lethality of the restraint practices in the U.S. (Weiss, Altimari, Blint, & Megan, 1998). One hundred forty two deaths were identified through a national survey that directly related to seclusion and restraint in the decade before 1998 (Erb, 2008). The five-part series from the Hartford Courant called 'Deadly Restraints' led to government hearings and law reform to protect the mentally ill population (Weiss et al., 1998). The U.S. General Accounting Office released a technical report supporting the findings of the Courant report and legislative hearings began (Huckshorn, 2004). "Regulatory agencies, licensing organizations and professional and advocacy groups" demanded the reduction in the use of restraints (Barton et al., 2009, p. 34). The National Association of State Mental Health Program Directors (NASMHPD) in a statement called for a reduction with the eventual elimination of seclusion and restraint (Huckshorn, 2004). In response to the social, cultural, and political awareness of restraint practices, the U.S. issued a Sentinel Alert related to restraint and seclusion use for psychiatric settings (Joint Commission on Accreditation of Hospitals, 2002; SAMHSA, 2006). One study indicated that the rise of injuries and violence

occurred as staff members were told not to use restraint but were not provided tools and techniques to manage the violence (Khadivi, Patel, Atkinson, & Levine, 2004).

Curran (2007) noted that there continues to be a strong stance with administrators, professional organizations, and regulating agencies toward the reduction of restraints. Six strategies for the reduction of restraints, which were developed by the NASMHPD (2008), guided the change. The strategies include organizational change, data to inform practice, development of the workforce, restraint and seclusion reduction tools, improving the patient's role, and debriefing techniques (NASMHPD, 2008). This report offered not only the latest evidence toward the reduction of restraints, but planning tools toward the achievement of the six strategies as well (NASMHPD, 2008). Several agencies, including the American Psychiatric Association (APA), American Psychiatric Nurses Association (APNA), American Hospital Association, National Association of Psychiatric Health Systems, and the Children's Welfare League and independent studies created policy statements with recommendations and scientific findings moving toward restraint reduction and elimination (APNA, 2007a; Huckshorn, 2004).

Current State of Knowledge

Restraint usage. The 'reduction of restraint usage' has been the phrase most familiar to nurses in the last decade. The efforts to reduce restraint usage in psychiatric settings are supported by institutional, state, and federal policies (Glezer & Brendel, 2010). Restraints are the last resort in a continuum of care for psychiatric patients (Steele, 2011). Restraint use is considered the "nuclear" option in the psychiatric-mental health field (Kenny, 2005, p.15). The use of restraints is an act of clinical judgment made by the psychiatric nurse who legally overrides the will and rights of the patient.

Patients who are restrained have displayed self-harm or violent behavior toward others (APNA, 2007b; Gelkopf et al., 2009; Stewart et al., 2009). The characteristics of the patient's clinical state are deemed more important than the staff's characteristics when managing escalating situations (Larue et al., 2009). Indicators for using leather restraints are likely to be patients who are also displaying unclear thoughts and an increase in vocal volume (Whittington, Lancaster, Meehan, Lane, & Riley, 2006). In a retrospective study, the antecedents to violence included positive psychotic symptoms, hostility, and agitation (Van Kessel, Milne, Hunt, & Reed, 2012). Knight (2011) interpreted clinical pre-restraint data that led to the discovery of four patient categories: rapid escalator (agitation, hostility, obvious anger, outbursts and threats), help seekers (depression, anxiety, fearfulness, and refusing support), disorganized (disorientation, confusion, fluid and food intake issues, illogical, and unable to care for themselves), and barely safe (similar symptoms to the rapid escalators and disorganized, yet could understand their situation, interact with staff, and responded to direction). These categories begin the identification of clinical symptomology, allowing nurses to make early identifications of escalating behavior (Knight, 2011). Some variables need to be examined further to determine their effect, such as psychotropic medication, diagnosis, legal status, and the patient's support system (Knight, 2011).

Other patient information associated with restraint can include diagnosis, symptoms, altered state of consciousness, age, developmental level, sex, legal status, number of admissions, history of violence, substance abuse, ethnicity, length of admission, time of day, or time of the year (Anonymous, 2001; Flannery, Farley, Tierney, & Walker, 2011; Knutzen et al., 2011; Di Lorenzo, Baraldi, Ferrara, Mimmi, & Rigatelli, 2012; Husum, Bjorngaard, Finset, & Ruud, 2010). Diagnosis related restraint prevalence such as patients with bipolar, personality disorder,

or schizophrenia is high (Chukwujekwu & Stanley, 2011; Dumais et al., 2011; Flannery et al., 2011; Husum et al., 2010). Psychosis is a symptom in which restraints are utilized when less restrictive alternatives fail (Huf, Coutinho, Adams, & TREC-SAVE Collaborative Group, 2012). Further research is necessary to continue to refine the diagnostic and symptomology connections (Chukwujekwu & Stanley, 2011; Huf et al., 2012.).

Tompsett et al. (2011) described variables related to the predication of restraint and recommended further research on this complex issue (Tompsett et al., 2011). The demographic of the patients in a study conducted by Stewart et al. (2009) has been identified as "young, male, and detained" (p. 749). Male patients are more likely to be physically restrained, as they are perceived to have a greater risk of being dangerous (Husum et al., 2010; Knutzen et al., 2011; Ryan & Bowers, 2006). Hendryx, Trusevich, Coyle, Short, and Roll (2009) found that 63% of the seclusion and restraint episodes were concentrated on 10 patients, otherwise known as high-risk individuals. A small amount of patients accounted for multiple incidents of seclusion and restraint, resulting in high seclusion and restraint hours, this population and these phenomena require further research (Lewis et al., 2009). The prevalence of an increase in restraint usage with immigrants occurs related to cultural barriers (Knutzen et al., 2011; Knutzen, Sandvikk, Hauff, Opjordsmoen, & Friis, 2007). Controversy is noted with the use of restraints with the patient population, especially if the patient is confused or frail (Chien & Lee, 2007). Conversely, the use of restraint in a pediatric population has been scarcely documented on its effectiveness in the literature (DeHert, Dirix, Demunter, & Correll, 2011). While diagnosis is a variable identified that increases restraint use, the profile of age, gender, and phase of hospital stay require further support in the literature (Keski-Valkama et al., 2010).

Principles of mental health recovery are defined universally with the Substance Abuse and Mental Health Services Administration (SAMHSA) (2012) and leaders in behavioral health care so that all the stakeholders have a common goal when working with patients. The historical mental health model perspective defines individuals with mental health disorders involving a lifelong, chronic, progressive disease process characterized by disabling signs and symptoms, which render the individual, a patient for life with a poor and relatively hopeless prognosis (Huckshorn, 2004). This is disappearing with the new Recovery Model (Huckshorn, 2004). The definition of this model is "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (SAMHSA, 2012, p.2). With restraint reduction being the priority for all, the opportunities for growth and education improve, allowing individuals, including children to succeed and continue the path to recovery while returning to community life (LeBel, Huckshorn, & Caldwell, 2010). Individuals who are struggling with a mental illness are not defined by it (Huckshorn, 2004). Four "dimensions that support a life" of recovery include "health," "purpose," "home," and "community" (SAMHSA, 2012, p. 3). The guiding principles are "hope, person-driven, many pathways, holistic, peer support, relational, culture, addresses trauma, strengths/responsibility and respect" (SAMHSA, 2012, p.4). It is with the employment of these recovery principles within the acute psychiatric-mental health setting that restraint reduction can be further reduced (Hendryx et al., 2009). Hope is a significant factor for mental health recovery. Renewed hope with these guiding principles and the subsequent new interventions can improve the lives of individuals with "severe and persistent mental illnesses" (Huckshorn, 2004, p. 27). Trauma informed care is a philosophy that focuses on understanding the relationship of trauma, well being, and quality of life, and with the early identification of past or current trauma and triggers,

restraint reduction can be promoted (Huckshorn, 2004). Many psychiatric-mental health patients have had traumatic experiences, including some within the psychiatric-mental health settings (Frueh et al., 2005; Robbins, Sauvageot, Cusack, Suffoletta-Maierle, & Frueh, 2005).

One method of addressing the recovery principles and to provide trauma informed care is using a psychiatric advanced directive (PAD). The PAD is document that is legally written by the patient during a time when the patient and significant others are not under immediate stress (Swanson et al., 2008). The patient documents his or her preferences regarding various aspects of psychiatric-mental health care, including de-escalation and restraint interventions (Glezer & Brendel, 2010; Swanson et al., 2008). Mental health recovery is a complex concept that requires individualized attention (Hejtmanek, 2010). This document guides caregivers regarding medications and other care such as restraint usage, allowing for the empowerment of the patient even in times of decomposition (Glezer & Brendel, 2010).

Alternatives in lieu of restraints. Patient-related violence is increasingly recognized as preventable (Benson, Miller, Rogers, & Allen, 2012; Livingston, Verdun-Jones, Brink, Lussier, & Nicholls, 2010). Society and legislation have demanded the use of fewer restrictive measures (Terpstra et al., 2001). The restriction on the use of restraint with even highly aggressive or potentially injurious individuals can create a serious degradation of the psychiatric-mental health milieu (Beck et al., 2008). The importance of identifying the escalation of aggressive behaviors early is the key to avoiding restraint and seclusion (Goetz & Taylor-Trujillo, 2012). Alternatives in place of using restraints need to be investigated to reduce "reactive, crisis-management orientation" practice (Mohr & Anderson, 2001, p. 141).

An all-inclusive list of alternative nursing interventions that works for each individual is difficult to ascertain, and further studies need to be conducted to determine quality and effective

interventions (Bak et al., 2012; Ryan & Bowers, 2005). Examples of the least restrictive alternatives include calming the environment, therapeutic communication, movement of the patient to an assessment area, and administering medications to create a safe milieu (Lewis et al., 2009; Moran et al., 2009; Short et al., 2008). Timeout is also noted as a less restrictive intervention, specifically compared to seclusion or restraint (Bowers et al., 2011). Sensory supports such as weighted blankets, watching fish, listening to music, aromatherapy, or taste coupled with individual-centered care are innovative alternatives to seclusion and restraint (Champagne & Stromberg, 2004). The use of comfort rooms is noted to reduce levels of distress for 92.9% of patients (Sivak, 2012).

The early identification of escalating aggression and the use of alternatives such as nursing interventions (being with and conversing with the patient or changing the environment), multi-professional agreements with the patient (predetermined), or the use of authority and power (presence near the vicinity of the escalating patient situation) were identified as alternatives to restraint in one study (Kontio et al., 2009). The use of less restrictive alternatives is a requirement by the Centers for Medicaid and Medicare Services (CMS) and The Joint Commission Centers (CMS, 2013; The Joint Commission, 2013). The International Society of Psychiatric-Mental Health Nurses' supports the rights of the individual to appropriate treatment and respect in the least restrictive manner (Anonymous, 2001). In a position statement, the American Psychiatric Nurses Association (APNA) (2007a) called for the elimination of restraints and highly supported the use of alternatives. The alternative(s) needs to be written in the patient record. If the least restrictive alternatives fail and the patient ends up with restraints, the progression of the least restrictive alternatives shows the individualization of care for the patient and is evident in the patient's record (Lindsay & Brittan, 2007). Individualization of person-

centered treatments and changes to the psychiatric-mental health environment need to be evaluated in order to avoid the use of restraint (Bak et al., 2012; Browne et al., 2011; Chau, 2010). It is through evaluation that individualized treatment can occur.

A key nursing intervention is to respond to the aggressive behavior of patients (Pulsford et al., 2013). The use of restraint can increase negative behavior in patients; however, the use of the least restrictive measures does not increase injury or harm and can avoid the presence of coercion (Ferlegen & Morrison, 2013; Huf et al., 2012). Negative outcomes are associated with restraints (Kruger, Mayer, Haastert, & Meyer, 2013). Patient-related violence is being recognized as preventable (Benson et al., 2012; Livingston et al., 2010). The nurse can increase his or her accuracy of aggression prediction with a combination of risk and nursing assessments and intuition while decreasing aggression through the application of least restrictive nursing interventions (Phillips, Stargatt, & Fisher, 2011; Ogloff & Daffern, 2006). Restraints are an extreme intervention and are a last resort for use (Kenny, 2005; Steele, 2011; Moran et al., 2009). The effects of restraint use are long lasting (Ferlegen & Morrison, 2013). The participant responses were consistent with the literature that the use of restraints is traumatic for staff (Ferlegen & Morrison, 2013; Huckshorn, 2006). Koukia, Madianos, & Katostaras (2009) found in a descriptive study that a majority of their participants would have preferred to "not intervene with critical incidents" (p. 327). Nursing staff have reported discomfort, strife, and confused feelings about the use of restraints, including personal conflict and guilt (Gelkopf et al., 2009; Roffe et al., 2007; Larue et al., 2009). Moran et al., 2009; Saarnio & Isola, 2010). Nurses are emotionally, psychologically, and physically affected by patient aggression as well as conflict and violence (Bimenyimana et al., 2009; Bowers, Brennan, Flood, Lipang, & Oladapo, 2006; McCue, Urcuyo, Lilu, Tobias, & Chambers, 2004). The preparation for restraint includes

education however the description of "its but spoils the job" and "after years of experience, I think you're prepared, but certainly not comfortable" highlights the staff experience with the decision-making and application of restraint (Bigwood & Crowe, 2008, p. 215). The assaults (physical and verbal) have been considered by the staff as a part of the job, and do not take legal action (Bilici, Sercan, & Tufan, 2013). The incidents of aggression are thought to be in mental health nurses' daily practice (Jonker, Goosens, Steenhuis, & Oud, 2008). Of interest is one mixed method study that showed the severity and frequency of injury to psychiatric nurses (Moylan & Cullianan, 2011). That same study included the finding that there was a delay in the decision to use restraints, if one of the nurses had been injured (Moylan & Cullinan, 2011).

The most frequent type of aggression is non-threatening verbal aggression (Jonker et al., 2008). The nurses in the quantitative cross-sectional study by Jonker et al. (2008) did not perceive the aggression to be a major problem for them. Historically, it has been the power struggles between staff members or between staff and patient that have been the impetus for the use of restraint (Curran, 2007; Ferlgen & Morrison, 2013; Van Doeselaar et al., 2008). A key role for nurses is to respond to the aggressive behavior of patients (Pulsford et al., 2013). The use of restraint can increase negative behavior in patients; however, the use of the least restrictive measures does not increase injury or harm and can avoid the presence of coercion (Ferlegen & Morrison, 2013; Huf et al., 2012). Negative outcomes are associated with restraints (Kruger et al., 2013). Patient-related violence is being recognized as preventable (Benson et al., 2012; Livingston et al., 2010). The nurse can increase his or her accuracy of aggression prediction with a combination of risk and nursing assessments and intuition while decreasing aggression through the application of least restrictive nursing interventions (Phillips, Stargatt, & Fisher, 2011; Ogloff & Daffern, 2006).

Bisconer, Green, Mallon-Czajka, and Johnson (2006) evaluated a patient through a case study design. This patient had an extensive history of aggression. The alternatives for this patient included a behavior plan focusing on positive reinforcement, replacement behaviors, and skills. In this case study, the treatment plan and staff members decreased the aggressive incidents. Aggressive patients can strike out and injure staff (Moyo & Robinson, 2012). Though restraints can prevent injuries, there is evidence that during the holding phase, the staff and patients can be hurt (Moyo & Robinson, 2012). The uses of alternatives that control aggression also prevent staff injury. NASMHPD (2006) recommended "six core strategies to reduce the use of seclusion and restraint" (p.1), including: "leadership toward organizational change" (p. 1), "data to inform practice," (p. 2), development of the workforce, use of reduction tools, patient roles in inpatient settings, and debriefing strategies (NASMHPD, 2006). Through collaboration and individualization, behavioral plans and nursing interventions can be successful (Bisconer et al., 2006; Irwin, 2006).

The literature describes nursing compliance with the use of restraint as a last intervention, despite the internal conflicts within the nurse. Moran et al. (2009) reported that in their focus group interviews, the nurses identified their attempts to avoid restraint and their realization that the use of restraint is the "worst possible scenario" (p. 601). Examples of alternatives included calming the milieu, therapeutic communication with the patient, movement of the patient to an assessment area, and administering medications to create a safe milieu (Lewis et al., 2009; Moran et al., 2009). Further research needs to be completed for the development of alternatives to restraint (Delaney, 2006). A prevention approach with continuous quality improvement and an ongoing reduction plan, which is individualized for the facility and the patient, will contribute to the scientific literature (Huckshorn, 2004). The prevention efforts require an ongoing

commitment and sustained attention to the details at the primary, secondary, and tertiary levels (Paterson, 2005).

Psychiatric nursing culture. The decision on whether to implement restraints for a psychiatric nurse is complex. Restraint use is a difficult clinical situation that needs to be evaluated in relation to the current dynamics (Lai, 2007). There is a lack of consensus and research on making this nursing decision. Curran (2007) described a scenario where some of the staff members could de-escalate a patient so that restraints were not applied after the patient had hit a staff member. Several other staff members were upset that the patient did not end up in restraints as the restraint was expected and the members felt that the patient had manipulated the nurse (Curran, 2007). Not all professionals are opposed to the use of restraints (Van Doeselaar et al., 2008). Curran (2007) described another clinical situation where the decision to utilize restraints was made. The crisis team staff unpacked the restraints and a set up a room in preparation to complete the restraint application. While the team set up the restraints and the room, the nurse continued therapeutic communication with the patient; with the passage of time and effective de-escalation techniques, the patient calmed. He was no longer a danger to himself or others. The crisis staff thought it necessary to follow through with the restraints because of the imminent risk at the time they had seen the patient. However, he was no longer a danger to himself or others. The indications for restraint were not present, yet staff members were frustrated. These scenarios provide examples of an incongruent psychiatric unit culture, expectations, and the complex context of clinical situations (Tanner, 2006).

A review of the literature described the difficulty in making on-the-spot clinical decisions by psychiatric nurses and revealed a theory-practice gap (Crook, 2001; Tanner, 2006). The criteria for the use of restraints are reported for the use of safety, including the endangerment of

self (patient) (CMS, 2012; Gelkopf et al., 2009; Lai, 2007). The framework for Crook's (2001) review of this literature based on the work of Benner (1984) and Schon (1983) identified the concepts of expertise and intuitive knowledge. Expertise and intuition come from time and an interactive, deliberate, reflective, and adapting practice (Crook, 2001; Tanner, 2006). The nurse "expert operates from a deep understanding of the total situation" (Crook, 2001, p. 3), and it is with the entire clinical picture of a patient that informed and appropriate decisions are made. Critical decision-making development for nursing interventions can avoid the use of restraints. In the decision-making process, the nurse needs to individualize less restrictive alternative interventions and patient's preferences (Bergk, Einsiedler, Flammer, & Steinert, 2011). Delaney and Johnson (2006) identified inpatient psychiatric-mental health nurses' skills to promote safety in a qualitative study. Themes that were discovered included being present and becoming aware, caring and connecting, balancing, and deciding how to respond.

Sound clinical judgment relies on the nurses to identify patterns, responses, and the positive engagement of psychiatric patients (Tanner, 2006). Interpersonal style is noted to be a key characteristic between staff and patients, and is relevant in aggressive patient situations (Daffern et al., 2010). Therapeutic alliance with a patient is complex and varied. More research on the connections between alliance and aggression needs to be completed (Cookson et al., 2012). Although a personal connection and interpersonal style are discussed in the de-escalation training at the psychiatric-mental health units that were studied, the informal use of first-person language has been noted to de-escalate many observed patient situations. During a crisis, the clinical situation can be charged with high emotions and the nurse makes quick decisions often in front of others (Crook, 2001). Larue et al. (2009) published a decision-making model illustrating the complex issues for the use of seclusion as a nursing intervention, including

equipment, environmental factors, organizational factors, and the integrated relationship of the patients and the healthcare providers. Seclusion as an intervention is a lesser restrictive measure as compared to the use of leather restraints, so this model can be considered.

Curran (2007) documented the continued stance for the restraint reduction movement by organizations, agencies, and administrators. Using reduction initiatives, restraints have been significantly reduced (Lebel, 2007; McCue, et al., 2004). Since the demand for a decrease in the use of restraints, psychiatric facilities have been able to document their successes. Goetz and Taylor-Trujillo (2012) identified nine elements in a patient-focused model that significantly decreased restraint episodes and staff injuries to improve and change the nursing culture. The elements incorporated in the model included "trauma-informed care, aggression management model, event review, leadership involvement, monthly quality feedback, recovery orientation, patient assessment, and collaboration" which were all implemented to improve and change the nursing culture (Goetz & Taylor, 2012, p. 97). Stewart et al. (2009) identified that education on restraint reduction is valued. The impact of education on nursing practice has not been fully evaluated. Restraint reduction efforts have traditionally been completed with some demonstrating success through various educational programs, such as the Crisis Prevention Institute (CPI) or Collaborative Problem Solving (Crisis Prevention Institute, 2012; Johnson, 2010; Martin, Kreig, Esposito, Stubbe, & Cardona, 2008; Smith, Timms, Parker, Reimels, & Hamlin, 2003). Chau (2010) identified the education and implementation of CPI as a turning point for a restraint-free environment. Aggression management programs alone can be effective; however, they require further research (Livingston et al., 2010). Lebel (2014) highlighted the first randomized control-trial research related to the reduction of restraint. In another study completed by Putkonen et al. (2013) in four high security mental health wards, the focuses of the

control-trial were men with psychotic illness. The uses of restraints were reduced in the control group after an educational staff intervention as compared to the comparison group (Putkonen et al., 2013).

Sclafani et al. (2008) utilized a nontraditional consultation process to respond to high-risk patient situations for a period of one month and the restraint episodes dropped from thirty-six to zero. The techniques that were utilized included focused staff training, unit projects focusing on hope and change, reinforcing staff support through coaching, and enhancing communication fostered coordination of services and programs (Sclafani et al., 2008).

Team coordination during a restraint process is critical to increase the safety of staff (Hendryx et al., 2009; Moyo & Robinson, 2012). This could be improved through a consistent education process (Hendryx et al., 2009; Moyo & Robinson, 2012). A terminology change toward an improved and empowering culture should be a part of the educational process to change the prison originated language to that of recovery for the patient and to change traditional historical perspectives (Benson et al., 2012; Paterson et al., 2009). Rapid response teams (Code Gray event at the focus facility) are highly effective as a "useful change vehicle" in restraint reduction (Prescott, Madden, Dennis, Tisher, & Wingate, 2007, p. 96).

The educational offerings need to be more comprehensive than simple de-escalation or aggression management. The topics need to include individualized assessments, developmentally appropriate treatment interventions, therapeutic alliance, therapeutic communication skills, self-awareness, precautions, risk assessment tools, clinical standards, ethical and legal issues, medications, safe monitoring, the aspect of supporting the staff and team in order to decrease aggressive or violent clinical situations, de-escalation, and follow-up (Anonymous, 2001; Benson et al., 2012; Berntsen et al., 2011; Cookson et al., 2012; Duxbury & Whittington, 2005;

Irwin, 2006; Kontio et al., 2009; Ogloff & Daffern, 2006; Roffe et al., 2007; Rydelius, 2007; Schreiner et al., 2004). In 2005, The SAMHSA (2012) published a manual to improve the tools and knowledge for direct care staff to eliminate the use of seclusion and restraint. The Psychiatric Mental Health Substance Abuse Essential Competencies Task Force of the American Academy of Nursing Psychiatric Mental Health Substance Abuse Expert Panel (2012) developed the curricula and competencies for psychiatric-mental health nursing profession for the nurse generalist. The competencies and curricula will be unfolding over the next few years. These elements assist nurses and staff in making incremental changes in their practice and therapeutic environment, which lead to an overall decrease in restraint and staff injuries (Borckardt et al., 2011).

The philosophy of decreasing restraints has been in place for several decades. The concepts within the use of restraint and control have negative connotations, and imply that the violence is viewed "as within the patient instead of seen as being co-createe" (Paterson et al., 2011, p. 16). Still, some nurses express negativity and concern regarding the techniques (Curran, 2007). A 2009 descriptive study discovered the goals for the use of patient restraint to include: helping a patient avoid self-harm, limiting violent behavior, avoiding harm to the environment, calming a patient, separating fights, stopping a brawl, showing the patient he did not behave well, and disciplining the patient (Chien & Lee, 2007; Gelkopf et al., 2009). The authors of this study indicated that nurses are experiencing difficulty in understanding that the only reason supported by law is for self-harm or harm-to others.

Moran et al. (2009) described the strife that nurses experience when restraints are utilized in the workplace. Caring for psychiatric, mentally ill patients is challenging when the patients are aggressive, which is when the difficulty substantially increases (Bimenyimana et al., 2009).

Nurses are on the frontline working with patients toward balance and wellness while de-escalating clinical situations (Terpstra et al., 2001). Nurses are emotionally, psychologically, and physically affected by patient aggression, conflict, and violence (Bimenyimana et al., 2009; Bowers et al., 2006; McCue et al., 2004). The experience has been described as "it's a part of the job, but it spoils the job" (Bigwood & Crowe, 2008, p.215). One nurse described the restraint event as follows: "after years of experience, I think you're prepared, but certainly not comfortable" (Chau, 2010, para. 10). The sub theme of control of the situation and maintaining a therapeutic relationship contributes to create conflict within the nursing staff (Bigwood & Crowe, 2008). The perception of control for patients and staff is dependent upon the individual patient situation (Leggett & Silverster, 2003). The variables to consider include medication, seclusion, restraint, and gender (Leggett & Silvester, 2003).

A hostile working environment can be disempowering for psychiatric-mental health nurses (Tema et al., 2011). Nursing staff need to be able to debrief the intense feelings that develop after escalating patient events so that the environment of the facility can remain balanced and therapeutic (Sequeira & Halstead, 2004). The identified themes are emotional distress and the suppression of unpleasant emotions. The emotional distress is described as ambivalence, uneasiness, anger, frustration, despair, hopelessness, helplessness, anxiety, guilt, and fear affecting both nurses and patients (Bimenyimana et al., 2009; Lai, 2007; Moran et al., 2009; Sequeira & Halstead, 2004).

The decision-making process for managing aggressive patients is fraught with ethical dilemmas (Kontio et al., 2010). The nurse's internal struggle with the decision to "get through" the restraint intervention creates suppression (Lai, 2007; Moran et al., 2009). Suppression not only creates conflict during and after specific episodes of restraint, but leads to the diminished

"well-being and morale" of all staff members (Moran et al., 2009, p. 601). Symptoms of suppression can manifest as substance abuse, retaliation, absenteeism, or the development of an, I do not care attitude (Bimenyimana et al., 2009). Nurses are emotionally uncomfortable with restraint and seclusion as interventions (Larue et al., 2009). The level of violence and aggression that a psychiatric-mental health professional is exposed to is overwhelming (Bimenyimana et al., 2009; Sturrock, 2010). Acts of violence and aggression in acute-care settings may be on the increase (Moylan, 2009). The ideal for nursing practice is to provide as much care with as much humanity and compassion as possible in violent, aggressive, and traumatic situations (Bigwood & Crowe, 2008; Moylan, 2009). Nurses have reported trying to treat the patient who is displaying disruptive behavior, as they would like to be treated themselves (Terpstra et al., 2001). The reduction of restraint includes a change in culture where, "getting hurt is not a part of the job" (Short et al., 2008, p. 1378).

Perceptions of nursing workload and unit activity are a continual topic of discussion in nursing circles (Baker & Munro, 2006; Van Bogaert et al., 2013). Nursing staff ratios to patient acuity is an ongoing concern in psychiatric nursing (Delaney & Hardy, 2008). The ratio of staff members to the number of patients can make a difference regarding restraint reduction; this topic requires further research before generalization (Donat, 2002). During clinical shifts, the acuity can change and a patient who is escalating requires more nursing time, so the perceived workload is believed to increase (Gerolamo, 2009). Adequacy of staffing may be perceived as enough to handle the workload on the shift until a crisis event occurs. Perceived feelings of safety also change depending on the acuity of the patients in the psychiatric milieu. Gerolamo (2009) explored the staffing adequacy perceptions and correlated support related to a higher unit activity and the situational clinical perceptions by nurses are accurate. This was determined by

an exploratory analysis with a correlational matrix. This study supported the use of a case study on a successful unit to gather nursing perceptions related to restraint removal from psychiatric-mental health units. The nurses' perceptions are a significant data element within the Gerolamo (2009) study. The clinical area of geriatric nursing presents supporting information indicating that workload and patient safety are the two main reasons that restraints are used (Lane & Harrington, 2011). The inclusion of nursing staff perceptions is critical to the adoption of change, including the removal of restraints from units.

The beliefs, perceptions, and practices of any given nursing unit can allow or stop a change in culture. Chien and Lee (2007) discussed that the view and attitude of the nurse may create conflict related to the autonomy and rights of the patients. Lane and Harrington (2011) described the need for nurses need to be cognizant of their role in perpetuating the continued use of restraints. The actions and the nurse's emotional reactions surrounding the decision to restrain patients influence the therapeutic message that the patient perceives (Gelkopf et al., 2009). Nurses may interpret the traits of the patient in a negative manner (fear or anxiety), and in turn can provoke reflexive responses and lead to a premature expectation of violence (Larue et al., 2009). Mental illness has been identified as a primary reason for aggression (Duxbury & Whittington, 2005). A positive attitude toward patients with mental health issues can positively influence a stressful clinical situation (Bowers, Alexander, Simpson, Ryan, & Carr-Walker, 2005). Movement away from reliance on medication and replacing this with the improvement of therapeutic communication skills may be essential for the ongoing reduction of violence (Duxbury & Whittington, 2005). A change in daily practice terminology from the idea that restraint is a nursing intervention to an unusual emergency procedure will assist in the critical thinking of an emergent clinical situation (Delaney, 2006).

Staff-related factors also have an influence on the interpretation of clinical situations, including ratio of staff to patient care, age, sex, experience, training, turnover, and attitudes (Husum et al., 2010; Pollard, Yanasak, Rogers, & Tapp, 2007). However, the extent of the influence on the staffing and rate of violent clinical situations is unclear (Staggs, 2012). In addition, the association between violent clinical situations and nursing experience has not been studied (Staggs, 2012). While voicing high ethical principles toward restraint reduction, organizations have not always demonstrated enough manpower to meet the principles (Kontio et al., 2009). The other factor that needs to be considered is the individualization of care and that policies and procedures may be a barrier to individualization (Huckshorn, 2004).

The solidarity of the healthcare team is the key in de-escalating patient situations (Larue et al., 2009; Sullivan et al., 2005). Team members need to be able to depend on each other (Chau, 2010). A contributing factor toward aggression is the lack of support in teams (Bimenyimana et al., 2009). There are norms within the team environment that require further research in order to fully understand judgments and values (Larue et al., 2009).

Views of patients and significant others. The patient and family perspective related to the use of restraints can propel change for the restraint-free trend. Kontio et al. (2012) concluded that the patient's perspective was not given sufficient attention during a restraint episode. Post-restraint debriefings are a requirement of CMS (2013) and The Joint Commission (2013). Debriefing is a term for the emotional support of the patient during and after an episode of restraint with the intent of providing individualization. The knowledge gained from the analysis of the restraint event through a debriefing process can mitigate the traumatic effects of restraint and inform future educational topics (Huckshorn, 2004). Ryan and Happell (2009) discovered

that the studied facility was meeting the intent of the mandated debriefing, but the requirements were not benefiting the patient as intended by CMS and The Joint Commission.

A consideration noted in the Moran et al. (2009) study included the disruption of the psychiatric milieu and the effect of a restraint occurrence on other patients in the unit. Milieu management is a major responsibility of a psychiatric nurse. In psychiatric settings, the patients are mobile and have common areas to interact and improve their mental health. This becomes problematic when there is a disruptive environment, as other patients can trigger an increase in their symptomology (Moran et al., 2009).

The views of the patients and their significant others include physically and emotionally damaging effects and have been described as aversive and traumatizing (Azeem, Aujla, Rammerth, Binsfeld, & Jones, 2011; McCue et al., 2004). Patients have reported negative effects associated with the use of restraint, including anger, fear, bitterness, and a negative view of therapeutic staff (Knight, 2011; Steinert, Bergbauer, Schmid, & Gebhardt, 2007). Patients reported feelings of shame, injustice, abandonment, and neglect from containment nursing interventions (Bonner, Lowe, Rawcliffe, & Wellman, 2002; Holmes, Kennedy, & Perron, 2004). Poor communication and environmental conditions are a precursor to some patients' aggressive events (Duxbury & Whittington, 2005). Consumer participation in inpatient settings should be included to help in restraint reduction as an influence for patients and staff (Bluebird, 2004; Huckshorn, 2004). The adult psychiatric-mental health unit has a peer specialist employed for this very purpose.

Leadership views. The restraint reduction movement continues to be actively sought by administrators, agencies, and organizations (Curran, 2007). The best practice for the psychiatric patient, as determined by Disability Rights for California, is the reduction of restraints

(Morrison, 2013). As a best practice, there would be fewer injuries and deaths (Morrison, 2013). An adjunct benefit to leadership is the reduction in cost. Facilities are continually evaluating the cost of services. Morrison (2013) estimated the cost of one episode of restraint to range from $302.02 to $354.51. LeBel and Goldstein (2005) demonstrated a 92% reduction in restraint costs with the implementation of a restraint reduction intervention. Other hidden costs that can improve from the reduction of restraint are a decrease in staff-turnover and an increase in job satisfaction as emotional strife diminishes (Morrison, 2013). The APNA position statement (2007a) stated that the responsibility for the welfare and safety of psychiatric patients and staff rests with nursing and organizational leadership.

Accreditation and licensure are vital for healthcare organizations to stay in business. Agencies such as The Joint Commission, Centers for Medicaid and Medicare Services (CMS), and the Department of Justice (DOJ) provide approval for operations allowing continued healthcare delivery through accreditation and regulation. These agencies have specific criteria that need to be met and maintained during the accreditation and licensing period, such as the use of restraint or seclusion only being utilized when there is a risk of the patient hurting themself or others as a primary justification (APNA, 2007b; CMS, 2013; The Joint Commission, 2013; Holstead et al., 2010; Smith et al., 2003). When there is a reportable occurrence at an accredited and licensed facility, such as the death of a patient within 48 hours of a restraint episode, there will be an investigation (The Joint Commission, 2013). These standards are required to help management and staff focus on the well being of the patient, while creating a clinical environment to reduce the use of seclusion or restraint (Staten, 2003).

Criminal prosecution and civil litigation are also important views for leaders. Patients, families, and significant others may press charges after the occurrence of restraint, depending on

their perspective or outcome of the restraint episode (Morrison, 2013). Upon admission, each patient signs consent for services. This includes full disclosure regarding the use of restraints (Mohr & Nunno, 2011). The charges can include assault and battery, negligence, malpractice, civil rights violations, and wrongful death or homicide (Morrison, 2013). Coercion of a patient is a threat to the quality of care and ultimately, their recovery (Husum et al., 2010). Kress (2006) did describe that coerced treatment occured when the nurses thought there was appropriate justification of harm to oneself and others. Even an accusation of any legal wrong doing promotes poor staff morale and can damage patient confidence as well as the reputation of an organization (Lindsay & Brittan, 2007).

Administrators and leaders have a grander influence on restraint usage than the clinical presentation of the patient (APNA, 2007b; Chau, 2010; Ferlegen & Morrison, 2013; Ryan, 2009). Leadership philosophy and practices need to be grounded in safely changing the traditional practices (Benson et al., 2012; D'Orio, Wimby, & Haggard, 2007). The priorities of the administrative and clinical practices need to highlight the importance of safety and restraint reduction (Donat, 2003). When selecting staff for employment the ideal characteristics would include exemplar critical decision-making, awareness, education, and competency (Anonymous, 2001; Rydelius, 2007). Staff awareness of their behaviors and reactions contribute to the reduction of restraint usage (Fralick, 2007). Leadership and staff have shared roles in the success of restraint reduction and elimination, including shared beliefs and behaviors (Huckshorn, 2012). The principles of recovery need to be the focus of the treatment environment (Huckshorn, 2004). The leaders need to have a clear leadership style and specific plan tied to the mission and philosophy of the organization (Huckshorn, 2004).

There were “six core strategies for the reduction of seclusion and restraint” developed by program directors and include “leadership toward organizational change” (p. 1), “use of data to inform practice” (p.1), “workforce development” (p. 2), reduction tools, improving the patient’s role, and debriefing strategies (Huckshorn, 2004; Huckshorn, 2005; NASMHPD, 2006,). Data collection to inform practice tools will support recovery and sustain the reduction with the subsequent elimination of restraints (Huckshorn, 2004; Ryan, 2009; Sullivan et al., 2005). With data collection, there will be a development in the restraint data and indicators (Beck et al., 2008; Huckshorn, 2012). This will improve the evaluation of data and in turn; positive supervision will be developed without punitive measures toward staff.

Empowerment and motivation are staff tools that can be used with patients for the reduction of restraint and improving safety (Sullivan et al., 2005). Also noteworthy is that nurses who are associated with restraint usage can be described as victims of the system Lai, 2007). The complexity of the expectations of the leadership and the skill level of the team and other critical resources are not always available during the clinical decision-making process (Lai, 2007). It is important for leaders to evaluate failures and identify system improvements (Tucker & Edmondson, 2003).

The leadership of a facility sets the practice tone for the staff. Expectations of management assist in setting parameters, and changing negative role perceptions and attitudes, which can improve the opportunity to educate staff in decreasing cultural bias and restraint reduction (Ferlegen & Morrison, 2013; Paterson et al., 2011; Pollard et al., 2007; Sivakumaran, George, & Pfukwa, 2011). Leadership oversight regarding restraint usage can lead to a reduction (Hendryx et al., 2009). The empowerment of nursing staff through ongoing and problem-based education, appropriate infrastructure, resources, information, opportunity, support, feedback, and

growth needs to be in place for the success of restraint reduction and elimination (Chandler, 2012; Kontio et al., 2009; Tema et al., 2011). There needs to be empowerment, inclusion, education, and support of the patient, significant others, and advocates for the reduction and eventual elimination of restraint reduction (Chandler, 2012; Huckshorn, 2004). It is the responsibility of the leader to role model and to provide these opportunities for the patient. The change in the clinical environment is the key (Sullivan et al., 2005).

Restraint-free. The reduction of restraint usage continues to be successful, to the extent that many facilities are striving to be restraint-free (Goetz & Taylor-Trujillo, 2012; Knight, 2011). In some countries, restraint and seclusion are forbidden (Steinert et al., 2010). The state facilities in Pennsylvania have "virtually eliminated" restraint and Australia has also reduced restraint in residential settings (Grigg, 2006, p. 224). In 1839, Connolly, a psychiatrist from Britain, began to advocate for the elimination of restraints; he later wrote The Treatment of the Insane without Mechanical Restraint in 1856 (Lewis et al., 2009). The APNA (2007b) has taken a strong stance toward the movement to the "ultimate" elimination of restraints and supports preventative measures (p. 1); this was over six years ago. However, some facilities are not as successful with the full adoption of the least restrictive alternatives to restraints (Kontio et al., 2012). In order for a facility to become restraint-free, their success of restraint reduction needs to be evaluated. The Crisis Prevention Institute education was identified as a turning point for one restraint-free environment (Chau, 2010). Even with the strictest of attention paid to the l.prevention and reduction, Paterson (2005) discussed that the use of restraint may not be entirely excluded from consideration.

The public and political call for the reduction of restraints continues toward the trend to have restraint-free facilities. Restraints are a last resort nursing intervention (Chau, 2010; Lewis

et al., 2009). The risk of injury to staff and patients, including patient death is very high. A multi-focal and multidisciplinary approach needs to be the goal to decrease and therefore, lead to the elimination of restraints for inpatient psychiatric units, while also emphasizing person-centered care (Bak et al., 2012; Barton et al., 2009; Goetz & Taylor-Trujillo, 2012; Green, 2010; Linette & Francis, 2011). More than one issue affects the clinical situation during an escalating patient event, such as an intrusive environment, over stimulating activities, and the perception of the nursing intervention or de-escalation technique (Chau, 2010; Hendryx et al., 2009; O'Brien & Cole, 2004). The reduction of restraints has been more successful when all disciplines working with the patient have increased input into patient-care planning (Sivakumaran et al., 2011). A multiple strategy approach demonstrates restraint reduction (Delaney, 2006).

Environmental changes decrease the incidence of restraint, including lighting, open areas, visibility of the nursing staff when they are in the nurse's station via shatterproof glass, and privacy and meditation areas (Husum et al., 2010; Larue et al., 2009; Sivakumaran et al., 2011). Changes to treatment-related factors such as clear documentation protocol, medications, treatment philosophy and ideology, policy and procedure, and unit routines contribute to the decrease in restraint rates (Husum et al., 2010; Sivakumaran et al., 2011). Reduction programs with the proper mix of focused leadership with staff involvement at all levels of the organization can reduce restraints to a level where it is rarely used as an intervention (Lebel, 2007).

Design and Methodology

The methodology selected for the study was qualitative, and the design an exploratory case study analysis. The choice of a qualitative method allowed the researcher to explore new themes and key concepts to exhaust the collection of data while focusing on the perceptions of the participants. Through the adoption of a qualitative research design, the data collection

allowed for an interpretative, broad, and inductive quest for new knowledge instead of a quantitative research design, which defines relationships and arrives at precise outcomes (Burns & Grove, 2011). A qualitative study seeks to answer the research question that is the focus of the study with an inductive evolutionary process (Schram, 2006). The central question posed for the qualitative study was: How has the reduction of mechanical restraints on the psychiatric-mental health units impacted the practice culture? An area of additional inquiry was the sub question: What is the perception of the psychiatric nurses toward a mechanical restraint-free practice with acute psychiatric inpatients? The focus of qualitative research was on a working notion of the how and why of incorporating the concepts, assumptions, and expectations of the research questions (Schram, 2006). Assessing the link between the research topic, problem, purpose, and the research question provided a measure of the fit. In qualitative research, the propositions begin the research process but do not confine the process, as the discovery of phenomena can take the qualitative researcher in a different direction during the focused interviews.

Research using a qualitative approach investigates the meaning of an experience or event by the participant while focusing on the topic under research consideration (Schram, 2006). The perspectives and experiences of the nurses were explored in real-world conditions to analyze the complex issue (Yin, 2011). As the interviews with the nurses were conducted regarding the success in restraint reduction and the restraint-free trend, the participants' perceptions provided meaning to the phenomenon under study, allowing for a greater understanding of how the restraint reduction occurred and insight into implementing a restraint-free facility (Burns & Grove, 2011). Through the exploration of the bedside nurses' perceptions success in reducing restraint use and the restraint-free trend through their insight into this emerging development

contributed to the science and practice of the field. The dissertation topic of perceptions toward a restraint-free practice was a unique and clinically relevant research topic (Yin, 2011).

Hahn, Needham, Abderhalden, Duxbury, and Halfens (2006) completed a quantitative study on patients' aggression and management. In their conclusion section, they found that education alone did not change staff attitudes. In fact, their statement was that qualitative studies needed to be conducted to assist in identifying the intricacies that cannot be captured in a quantitative study of this kind. Delaney and Johnson (2006) described rich data and constructed a theory on the de-escalation process. Through the collection of the details related to a restraint-free environment, the richness of the participants' experiences is documented. Studies such as Hahn et al. (2006) and Delaney and Johnson (2006) highlight the importance of using a qualitative design that assists in the understanding of the successes nursing staff have had with reduction and elimination of restraints.

Several types of designs are available to a qualitative researcher, including narrative inquiry, grounded theory, ethnography, phenomenology, and case study approaches. After careful consideration of each of the design choices, a case study approach was determined to be most appropriate as there is a defined case or unit of analysis that needs deeper exploration. A case study approach was ideal for exploring the research questions, as the focus of the case design is to understand what successes occurred and what a restraint-free unit means to the interviewed nurses (Mauk, 2009). Within the case study design, there are many options, including single case and multiple case designs (Yin, 2014). The sample for the current case study research included several individuals within one unit of analysis, defined as the two psychiatric-mental health units focusing on a common concept or phenomenon, restraints and restraint-free. Using the single case focusing on the hospital's psychiatric-mental units as a unit

of analysis combined with an inductive process, the researcher's interaction with the participants remained open-ended, focused on building, not leading, the study interview responses, thus avoiding bias.

In addition to the type of design selected, the purpose or intent of a case study needs to be identified to guide the structure of the single case study (Yin, 2014). A qualitative case study allows for study of the complex phenomenon (Baxter & Jack, 2008). The single case study purposes include exploratory, descriptive, and explanatory approaches (Yin, 2014). Exploratory approaches permit a researcher to investigate and understand the phenomenon while identifying important thematic categories or generating further research (Hancock & Algozzine, 2011; Marshall & Rossman, 2011). A descriptive approach allows the researcher to document and describe the study phenomenon (Marshall & Rossman, 2011). Explanatory approaches let researchers explain patterns and identify plausible associations that shape the phenomenon and the purpose is to "identify the research questions or procedures to be used in a subsequent research study" (Marshall & Rossman, 2011; Yin, 2014, p. 238). The purpose for the case study is for the researcher to understand the phenomenon of the successes of the restraint reduction and perception of a restraint-free practice; therefore, an exploratory case study. Patterns and associations that shape the phenomenon can be discovered for the explanation of the success in the reduction of using mechanical restraints.

Components of an exploratory case study. The choice of the qualitative approach is significant at all stages during the research study, as it added depth and breadth to the information obtained from the participants. Through an exploratory case study method, a researcher seeks to describe a social phenomenon through the gathering of in-depth details of the phenomenon (Yin, 2014). The exploratory case study method is a scientific inquiry that satisfies

research questions surrounding the specific phenomenon and therefore, perspectives within a study (Hancock & Algozzine, 2011). Yin (2014) highlighted five components for case study research: the case study questions, propositions, unit of analysis or the case that needs to be studied, the "logic linking the data to the propositions," and the "criteria for interpreting the findings" (p. 29) . These five components are addressed in the following sections.

The exploratory case study components are part of a dynamic process in which the researcher is focused, interactive, active, and adaptive with the data from the case to study in order to comprehend the meaning of the collected information (Yin, 2014). These characteristics are also consistent with the concepts within the psychodynamic nursing and human caring. The researcher is purposeful in listening and collaborative through sharing acts of caring throughout the interview. As an active and adaptive researcher, the participant continues to be engaged while the researcher creates relevant, open-ended questions to the responses of the participant (Smith & Osborn, 2007; Yin, 2011). The basic assumptions of phenomenology also inform case studies and include (a) the understanding of human behavior is in the context of relationships to things, people, events, and situations; (b) perceptions present individuals with evidence of the world as it is lived. Therefore, understanding perceptions within the individual's experience and accounts determines that evidence; (c) the reality of an experience is directly related to the individual's consciousness of it, or the intentionality of consciousness; and (d) language is the way the lived meaning of the participant is conveyed and constructed. The meaning of the language becomes revealed through dialogue and reflections (Schram, 2006).

The key features of exploratory case study research are to examine the phenomenon of a particular single unit or system in order to contribute to knowledge of complex social phenomena (Yin, 2014). Psychiatric nursing "employs a purposeful use of self as its art and a wide range of

nursing, psychosocial, and neurobiological theories and research evidence as science" (APNA, 2007b, p. 11). This study was conducted with ongoing intentionality and purposefulness. With this detailed research study, the intentions and protocols are clear, providing direction as the study progresses to the final analysis and documentation. Purposefully fulfilling the details of this study is an ethical manner is a major focus in the study protocols.

Background of qualitative case study. Exploratory case study as a method focuses on the real-life context to answer research questions leading to insight related to the phenomenon (Amerson, 2011). Through this focus, the perception of psychiatric nurses regarding their facility being restraint-free was discovered. Through careful listening and following the interview-disclosed concepts or experiences without judgment or prejudice, the core themes related to becoming restraint-free were revealed. The data was collected through interviews focusing on the participants' past and current experiences with the combination of the past, present, and future to describe their future perceptions.

Historically, case study methods have been a part of social research. The use of qualitative studies has been questioned as legitimate research and has been debated by the followers of 'hard science' (Harvey, 2009). Qualitative research has value and adds knowledge. Several researchers have clarified the importance of the use of case study methods. This creative and out of the box thinking has led to the understanding of events or processes within the context of the phenomenon (Amerson, 2011). Case studies can be located within many disciplines, including nursing, to explore complex processes or events. Ever, Ploeg, and Kaasalainen (2011) utilized an exploratory case study design to contribute to geriatric nursing knowledge. A case study of nursing students led to the discovery of themes that can assist with the care of the aging population and their complex needs (Evers, Ploeg, & Kaasalainen, 2011). Amerson (2011) called

for further use of case-based studies so that this method of inquiry can become a part of improving nursing education and patient care.

The strength of a case study method in the previous studies demonstrated the significant and in-depth addition of knowledge for several disciplines. The psychiatric-mental health nursing profession, through a case study inquiry related to the perceptions toward a restraint-free hospital, was provided new knowledge for nursing education and patient care. It is through the discovery of facilitator and barrier themes that psychiatric-mental health nursing knowledge can be improved.

Quality criteria. Yin (2014) supported the use of the logical tests that have been universally accepted in quantitative research as applied to case study research. Yin (2014) identified the tests as "construct validity," "validity," and "reliability" (p. 46). Both statements inform the quality criteria for this dissertation. External validity focuses on analytic generalization in contrast to statistical generalization, which is seen in quantitative studies. Analytic generalization is the use of logic that extends the findings of this study to similar settings outside of the unit of measurement (Yin, 2014). Credibility is also included within the validity realm and demonstrates how believable the study data is by the confirmation of the interpretation of the qualitative data, confirmed by the study participants, the researcher, and the dissertation committee (Yin, 2011). Reliability demonstrates that the results of a study would be the same if the study were repeated (Yin, 2014). By confirming the research data, the study design should reach the same conclusions (King & Horrocks, 2010).

Theoretical Framework

The intent and purpose of a theory is to describe and guide the worldview of the researcher toward the linking of the study's findings to the body of nursing knowledge. A

communication of ideas toward the essence of nursing practice is developed for final analysis and interpretation (Walker & Avant, 2005). Nurses for the last 50 years have been utilizing theory to legitimize practices by documenting nursing science in an empirical manner. Nursing knowledge has been developed through conceptual models and nursing theories (Fitzpatrick & Whall, 2005). Conceptual models inform practice, education, and research (Fitzpatrick & Whall, 2005). Nursing-specific theories inform rational thinking, seeking to comprehend meaning toward decision-making in practice.

Nursing theory includes a metaparadigm that guides practice and research (Fawcet, 2005). The metaparadigm includes the concepts of nursing, health, person, and environment. These concepts are defined differently within each nursing theory. The metaparadigm unifies each nursing theory, making it specific to the discipline of nursing (Fawcett, 2005). The framework of a study provides a logical structure for the linking of the findings to the body of nursing knowledge.

A nursing theory that explains the nursing relationship process is Hildegard Peplau's theory of "interpersonal relations" or psychodynamic nursing (Peplau, 1952, p. 4). Other nursing theories incorporated into the theoretical framework for this study were Roy's (2011) "adaptation model" (p.1) and Watson's (2010) "theory of Caring" (p. 1). Peplau's psychodynamic nursing is an interactive theory, Roy's adaptation model is described as systems theory and the theory of caring is a developmental theory (Tourville, 2003).

While each of these nursing theories is well established and tested for application in nursing practice, Peplau's mid-range theory has the opportunity for growth while improving the practice of nursing (Fawcett, 2005; Peplau, 1952). Peplau's theory was most applicable to this study in that there is involvement of interpersonal relationships at many levels, including the

relationship between the researcher and participant and the historical relationships of the participants with patients. Part of the theory includes a focus on the observation of "the nurse, the patient [participant], and the relations that are studied" (Peplau, 1997). It is the impact of those relations that is examined related to the nursing profession and the care of the patients [participants] (Peplau, 1997). An underlying assumption to the psychodynamic nursing theory is that all interactions are unique and progress in an overlapping linear fashion (Peplau, 1952; Peplau, 1997). Peplau's theory is based on empirical information and historical use is one of the first theories of nursing and described as a science and an art (Peplau, 1997; Winters & Ballou, 2004). Watson's (2010) "theory of Caring" (p. 1) and Roy's (2011) "adaptation model" (p.1) were also incorporated into the theorectical framework for this study. A caring moment is to "come together in a human-to-human transaction that is meaningful, authentic, intentional, honoring the person, and sharing human experience that expands each person's worldview and spirit leading to new discovery of self and other and new life possibilities" (Watson, 2010, p. 1). Watson's theory of human caring strengthened the interactions and relationships of the researcher and the participant through the use of the nurse's use of caring moments (Chinn & Kramer, 2004). Adaptation is the main concept in Roy's Model. Cognition and emotion are considered as the person [participant] adapts (or does not change) in response their environment or system (Roy, 2011). Roy's adaptation model informs the adaptation system that occurs from modification in relationships and defines the changing and fluid nature of the integration of psychodynamic nursing with elements of human caring.

The aim of psychodynamic nursing is to "promote favorable changes in patients [participant]" and to "aid nurses in enlarging their understanding of what transpires during the nurse-patient [participant] relationships (Peplau, 1992, p. 13; Peplau, 1997, p. 162).

Understanding of the participants' perceptions related to the behaviors in the past and present related to restraint usage and reduction in the use of restraints provided the data from the nursing participants for the study. Identification of needs guided the theme identification. The framework for this study was grounded in Peplau's psychodynamic nursing three phases, which are orientation, working, and termination (Johnson, 2006). Orientation is the trust building and problem-defining phase (Peplau, 1952). The working phase is where problem solving and therapeutic responses from the participant assist the participant to the last stage, which is resolution (Peplau, 1952; Peplau, 1997). There is a goal selection, based on the patient [participant] and the patient's [participant's] capability of coping with issues or situations (Peplau, 1952; Peplau, 1997). The working phase is where there is problem-solving; interviewing and therapeutic responses are used to assist the patient [participant] toward the last stage, which is resolution (Peplau, 1952; Peplau, 1997). Resolution is a "freeing process" (Johnson, 2006; Peplau, 1952, p. 41). All participant needs identified in the orientation and working phase are prioritized for a successful termination from the nurse-participant relationship. This was a collaborative process with the participant and the nurse (Johnson, 2006).

Pragmatic adequacy relates to the practical application of Peplau's theory. This includes practicality in nursing education and nursing practice. The uses of Peplau's theory in education, include the psychodynamic nursing theory for inclusion in nursing education so students have an opportunity to study what happens when a nurse and a patient come together to work on a health problem" (Peplau, 1952, p. 261). Productive learning needs to be part of student education so that there can be an expansion and growth in the student's skills (Peplau, 1952). Nursing practice is the application of interventions to promote favorable changes in the patient and this is accomplished with clinical methodology, which includes observation, communication, recording,

and data analysis. Examples from the literature about the use of Peplau's theory in practice include application of the theory in a correctional environment, incorporation in individual therapy, and case management. It is through these differing populations and settings that there is evidence in the published literature that Peplau's theory can be used in multiple areas of nursing practice (Peplau, 1992; Fawcett, 2005). Nystrom (2007) examined the application of Peplau's theory and described it as a theory that will assist in understanding the patient's existential position. An additional publication supporting this 1950's based nursing theory in practice is from Hrabe (2005). Hrabe (2005) completed an analysis of Psychodynamic Nursing related to computer-mediated communications using the theory (Hrabe, 2005).

The specific influence of psychodynamic nursing with elements of human caring and the adaptation model on the research topic of perceptions of a restraint-free environment was to guide the relationships and interactions between the interviewed nurses and the researcher, while remaining focused on gaining insight into the research participants and guiding the analysis of data. The propositions from the psychodynamic nursing metaparadigm are that nursing interventions are beneficial to patients (participants), the interactions between patients (participants) and nurses can be studied and understood, there are identifiable phases in a nurse-patient (participant) relationship, and that the phases are applicable to all nursing situations (Fawcett, 2005; Peplau, 1952). Human caring moments and the dynamic nature of Roy's adaptation model combined with the psychodynamic nursing metaparadigm and claims influenced the study protocol and interpretation.

Practical Significance and Literature Review Summary

In evaluating the literature on restraint reduction and restraint-free practices, it became clear that there is literature to support the exploration of restraint-free environments from the

bedside nurse perspective, but there was minimal scientific research on this issue. The literature has a plethora of information on the two-decade rise to meet the call to reduce restraint usage. The literature on restraint-free peer-reviewed articles is minimal. Nursing knowledge will be expanded through a case study approach to gain the perspective of the bedside nurse while identifying themes from the data collection for further analysis and evaluation (Casey & Houghton, 2010). The themes that developed from this qualitative study provided insight into the practice and concerns of psychiatric nurses regarding the use of restraints. It is with the identification of these themes that nurses and nurse leaders can move forward toward a restraint-free environment, while being knowledgeable about potential barriers.

Chapter 3

Methodology

This research study employed a qualitative, case study research design, allowing the researcher to gather perceptions of psychiatric nurses on a restraint-free practice to gain an understanding on how to move toward a mechanical-restraint-free practice for one particular inpatient psychiatric hospital. The details of the methodology will be in this chapter including an exploration of the problem and purpose, research question, research site, design and method, research site, population and sample, data collection and analysis, quality criteria, limitations, delimitations, assumptions, researcher's role, and human subject protection as they relate to this study.

Problem and Purpose

The problem for study was the use of mechanical restraint for psychiatric-mental health inpatients. The reduction of mechanical restraints has been successful on the two psychiatric-mental health inpatient units where the research was conducted. The restraint episodes at the psychiatric-mental health units have significantly decreased in the last seven years, from 29 to 1 episodes per year. The purpose of this study was understand the perceptions of psychiatric-mental health nurses toward a mechanical restraint-free practice.

Research Question

The research question focused on the study problem and purpose. The main research question was: How has the reduction of mechanical restraints on the psychiatric-mental health units impacted the practice culture? An area of additional inquiry was the sub question: What is the perception of the psychiatric nurses toward a mechanical restraint-free practice with acute psychiatric inpatients?

Research Method and Design

The research method utilized for this study was a qualitative methodology. The appropriateness of a qualitative study related to this study is that the phenomenon being examined was professional experience collected to discover meaning (Burns & Grove, 2011). An exploratory case study design was used to guide the data collection and analysis procedures and analysis. Seeking new knowledge through an exploratory case study as a method focused on the real-life context to answer the case study research questions, which will lead to insight into the phenomenon (Amerson, 2011). The advantages of a qualitative exploratory case study is the data that is collected can help to focus future research questions or studies (Yin, 2014).

Research Site, Population, and Sample

The unit of analysis or case for this qualitative exploratory case study was two psychiatric-mental health inpatient units within a hospital considered to be an exemplar site as the restraint events have reduced significantly in the past seven years (See Table 2). This information is from the organizations seclusion and restraint use report. The organization uses a fiscal year as a calendar measurement. A fiscal year goes from July 1st to June 30th of the next year. The number of leather restraint episodes reported from the mechanical restraint use report was one in the past fiscal year. The setting of the behavioral health services included two units, adult and youth. The adult unit admits patients who are 18 years of age and up and has a capacity of 30. The youth unit admits children from 13 to 18 years of age and has a capacity of 15.

Table 2. Mechanical Restraint Report

Fiscal Year	Episodes
2008	29
2009	17
2010	3
2011	5
2012	2
2013	1
2014	1
2015	1

The population was all nurses who work directly with the two-inpatient psychiatric-mental health units, the unit of analysis. The total sample pool was 36 RNs. A subset of the population was determined by a purposeful selection of inpatient psychiatric nurses who met the specific study criteria (Burns & Grove, 2011;Tracy, 2013). The actual sample size from the subset was twelve nurses, which is 33% of the total sample pool. Purposeful selection is a type of sampling whereby particular individuals, activities, or settings are selected because the information that can be gained from these sources cannot be gathered from others (Burns & Grove, 2011; Tracy, 2013). The identification of the correct sampling frame was critical to gain information related to the restraint reduction successes and perceptions toward mechanical restraint-free practice from current psychiatric nurses so the sample can be varied enough to provide a holistic picture of these phenomenon.

The inclusion criteria included being a registered nurse, working in the analysis inpatient psychiatric unit, having at least one year of psychiatric–mental health nursing inpatient experience, and practicing in Nebraska. The experience requirement of at least 1 year ensures the nurse had multiple opportunities to participate in restraint reduction and de-escalation activities. The sample size was determined by saturation of the data from the interviews. Saturation was identified when no new information was discovered from the interviews of the participants (Burns & Grove, 2011).

Data Collection and Analysis

The qualitative data was collected through live, semi-structured individual interviews with open-ended questions. The interviews were audio-recorded and transcribed. The time set aside for each of the interviews was at least 60 minutes, the interviews ranged from twenty to sixty minutes. This type of collection allowed the researcher to focus on the perceptions of the psychiatric-mental health nurses. Letters explaining the research protocols were sent out electronically and through interoffice mail to the inpatient psychiatric nurses at the identified Nebraska medical facility (Appendix A). The names and phone numbers were obtained through the psychiatric-mental administrative staffing office. Interviews were scheduled at the convenience of the participant in an off unit location.

Interview Protocol and Validation of Data. The individual interviews provided the participants the opportunity to share their perceptions in a private setting. The individual interviews included semi-structured questions. The questions were listed in the interview protocol guide that was used to outline the main topics that were covered in the semi-structured interview (Appendix B). The purpose of the guide was to provide a flexible structure so that the interview flowed in anticipated and unanticipated directions related to the emerging themes,

using an inductive method (King & Horrocks, 2010). The interview protocol was expanded after completing two participant interviews. The incorporation of two additional questions was critical to keeping the interview protocol unique to the participant's experience (King & Horrocks, 2010). The changes included probing questions towards identifying facilitators and barriers regarding inquiry about the specifics that would allow the psychiatric-mental health units to go absolutely restraint-free. Regarding a practice change of removing the leather restraints from the unit of an off site utility room (Appendix B) during each of the subsequent participants' interviews, each participant was asked at the very least the following questions (a) what has been your role with homicidal or suicidal psychiatric patients and use of restraints; (b) how has the reduction of mechanical restraints changed your practice and the practice of the others on your units; (c) describe a time when a patient was placed in mechanical restraint; (d) if your unit were to adopt the mechanical restraint-free trend what would be your thoughts and feelings regarding the change; (e) what would it take to go restraint-free; (f) how has the move of the leather restraints to the off unit utility room made a difference in practice; and (g) what additional thoughts do you have regarding going mechanical restraint-free at the hospital? The individual interviews were critical to gathering qualitative data on the unique perspectives of the participants.

Before beginning the interviews, an informed consent was signed with an explanation, time was given for the participant to read the consent, and the opportunity for questions was given. The informed consent was signed; a demographic sheet was completed before the interview. The demographic form (Appendix C) collected information for description of the sample, so the participant population could be fully described. Information such as age range, years in nursing, and years as a psychiatric nurse was included on the form. The identification of

the participant being male or female was not included as to avoid potential confidentiality violation.

After the consent was signed and the demographic information was completed, the interview began. Following the Psychodynamic Nursing theory, with Caring Moments and Adaptation concepts, rapport was established with each participant so that the participant would feel comfortable sharing their answers. Before beginning the final analysis, the researcher met with the participant a second time, the participant was offered the opportunity to review and correct the transcribed interview. The participants validated the content of the transcript by signing and dating a transcript confirmation page (Appendix D). The signing of a separate page assures anonymity, as there is no identifying data on the transcript. The signature page was separated from the transcript and filed in the electronically locked computer file. The primary researcher is the only person able to identify the confidential information with the participant. One participant did correct the tense structure of one word. The participant writing on the transcribed interview paper did this. This researcher then changed the formal confidential transcript. One participant chose to withdraw her interview information due to personal and context concerns. The withdrawing participant would have preferred a written survey rather than the taped interview. The participant's data was not included in the analysis of the study data.

The raw data and taped transcripts will be retained for three years by the researcher in the locked password-protected electronic file with the originals destroyed. Once three years pass, the locked password-protected electronic file will be over written then placed in the trash bin of the computer, emptied, and therefore, destroyed. Member-checking was utilized to validate the accuracy of the the interview content (Cohen & Crabtree, 2006; Creswell, 2014; Harper & Cole, 2012). The participant reviewed the interview transcript and and signed a validation and

confirmation form (Appendix D). This process provides the participant the opportunity to evaluate the interview and correct any intent or wording (Cohen & Crabtree, 2006). After the remainders of the transcripts were validated the analysis and interpretation of the collected data was completed including the deconstruction of ideas and statements, expanding on the emerging themes for the future studies with other psychiatric-mental health nurses. Descriptive coding utilizing the perceptions of the participants was employed to identify patterns between the participants (Saldana, 2013).

Prior to conducting the interviews the researcher reviewed the theoretical framework for this study. Identifying the importance of a Peplau's (1997) three phases of psychodynamic nursing, the orientation, work, and termination phases were recognized in each interview. During the interview, Watson's human caring moments were inserted at various points to further strengthen the interview interactions. One of the methods of a caring moment during the interviews was active listening. The researcher intently heard the words spoken by the participants while staying connected through soft eye contact. Roy's (2011) adaptations concept within systems was evident in each interview as well. The interview protocol was used to begin the basis of an inquiry and when the inquiry or response threaded to another connected concept, the interviewer adapted by exploring the new concept in the interview. For example, one participant discussed that there was a change in the way the nurses at the facility changed their approach to the patients, the researcher then explored what specifically what that change was with that participant.

The researcher prepared for the interviews following the processes of qualitative interviews prescribed by King and Horrocks (2010). The specific processes included preparing the interview setting, recording, rapport building, how (not) to ask questions, probing, and

starting and ending interviews (King & Horrocks, 2010) The participants were self-identified or reminded of the volunteer opportunity to participate. Each interview was held in a private setting in the organization. One took place at the main facility per mutual agreement with the participant. The interviews were recorded using a audio digital recorder. The recorder allowed the researcher to improve validity of the spoken word. Field notes were also taken for each interview. This proved to be an important process when one of the interviews stopped recording during the last third of the interview. The researcher could reconstruct the ideas of the participant on the transcript, which was clearly marked. And the participant validated the transcribed conversation as well as the paraphrased conversation. As the interviews progressed and were transcribed, the researcher created journal entries for reflection and improvement of interview technique Schon, 1983).

Proposition. The first study proposition is that there will be varied, analytical, and logical convergence of themes from the data. The other propositions include the propositions from the Psychodynamic Nursing metaparadigm. The propositions are that nursing interventions are beneficial to participants. The interactions between participants and nurses can be studied and understood, there are identifiable phases in a nurse-participant relationship, and the phases are applicable to all nursing situations (Fawcett, 2005; Peplau, 1952). Knowing these study propositions creates a solid foundation in the data analysis stage (Yin, 2014). This knowledge allowed the researcher to accept all interview information from the participants by understanding that all data was significant. Understanding the propositions decreased researcher preconceptions and allowed for a productive analysis. The criteria for the interpretation of the case study findings developed from the nursing theory and pattern recognition. As the analysis unfolded, counter explanations were examined to strengthen the thematic findings (Yin, 2014).

Analysis. NVivo a qualitative, research computerized software was utilized as a tool to assist in the coding of patterns and matching data for the early identification of developing themes. The researcher in the form of a journal wrote analytical memos. The memos allowed for documentation of the qualitative process and reflection (Saldana, 2013). From this reflection process, the interview questions were evaluated and adjusted to maximize data collection, formulation and saturation. After the interview, the researcher transcribed the data for review in preparation for the validation process with the participant. The immediate transcription emphasized and maintained the idiography or unique nature of each participant's data. The use of the software technology and the researcher's nursing experience were used to inform the critical analysis of the data. The challenges of conventional classifications and generalizations familiar to the researcher were critically appraised so as not to distort or superimpose the uniqueness of this research data (Yin, 2011). For example, the use of restraints as a last resort is a concept that is taught in the Crisis Prevention Institute training (CPI, 2008). Each study participant has had this training and when completing the analysis many participants utilized this exact phrasing while others integrated this into their daily practice as demonstrated through their clinical actions (i.e. extensive verbal de-escalation). Each participant's perspective was carefully evaluated when considering the concept of last resort as a theme.

Saldana (2013) discussed data analysis as first and second codings; however, he also indicates that coding is cyclical and nonlinear. To describe the process of data analysis for this study Saldana's (2013) language was utilized. The first cycle coding for this study included the grammatical coding principles of attribute and simultaneous coding with the elemental principle of structural coding.

The use of attribute coding was completed with the demographic information to assist in describing multiple participants, such as age range and years of experience (Saldana, 2013). Simultaneous coding occurred when the data reported by the participants overlapped into two or more descriptive coding nodes (Saldana, 2013). The need for simultaneous coding was related to the complexity within the interview results (Saldana, 2013). The structural coding process allowed this researcher to standardize the data from multiple participants and focus on the research question: How has the reduction of mechanical restraints on the psychiatric-mental health units impacted the practice culture? Structural coding is suitable for interview transcript studies such as this research study (Saldana, 2013). The categorization technique of structural analysis allowed the researcher to take the main content or body of the participant data and organize the larger and smaller segments for the first cycle coding with the focus on answering the main research and interview questions (Saldana, 2013). A manual coding book was developed in addition to the information listed within the NVivo software program so that the emergent codes could be visualized on a hard copy. This allowed the researcher to organize, reorganize, and collapse the nodes into larger nodes or categorical themes. The first cycle coding can actually be considered a continuous recoding. As the coding nodes emerged from the participant data, the node titles changed multiple times in order to develop a logical metasynthesis of the data (Saldana, 2013). Each theme was evaluated, prioritized, and collapsed into current nodes or into subnodes. The value of this questioning and relentless search led to a solid reanalysis and confirmation of the previous structural coding. The first and second analysis coding cycles occurred during coding of the participant data within the NVivo software program.

After the first cycle coding a purposeful pause in the organization of the participant data occurred in order for the researcher to consider whether the first coding cycle was complete.

This pause allowed the researcher to consider the data from an observational perspective enhancing objectivity. A code mapping process was outlined to enhance the credibility, trustworthiness, and organization of the data. The primary iterations of code mapping included a list of the data by descriptive comment (see Table 3).

Table 3. Primary Iteration of Code Mapping

Primary Identified Codes
Reduction of mechanical restraints
Barriers for restraint reduction
Stressful
Decision-making process to use physical holds
Facilitators for restraint reduction
Decision-making process to use leather restraints
Safety
Nursing role with homicidal or suicidal patients

The ongoing iteration of code mapping included adding the details of each category for further analysis, condensation, and identification of central concepts (Saldana, 2013) (See Table 4). Documenting the outlines of the continual iterations created a transition to the second coding cycle method (Saldana, 2013).

Table 4. Ongoing Iteration of Code Mapping

Ongoing Identified Codes
Barriers for restraint reduction
Current practice
Limitations of law enforcement
Medication unpredictability
Mental health stigma
Perceived punishment
Staff intensive
Facilitators for restraint reduction
Administrative support
Alternatives tried
Caring rounds
Comfort rooms
CPI implementation
De-escalation techniques
Individualized care
Law enforcement
Older SWA program
Practice change related to reduction
Respectful of individuals
Screening process
Seclusion
Staff education
Staff experience
Trauma informed care
Weighted blankets
Wellness recovery action plan

Pattern coding was the second coding cycle method. This coding process includes exploratory and inferential statements that support the emergent theme (Saldana, 2013). The meaning of the data converged with the examples and quotations from the participant data. There was an ongoing refinement of the iterations of coding mapping nodes or themes. The final ongoing iteration of code mapping was completed for the final analysis (See Table 5).

Table 5. Final Ongoing Iteration of Code Mapping

Final Ongoing Identified Codes
Barriers for restraint removal out of the building
Current practice
Medication
Patient acuity or behavior
Facilitators for restraint removal out of the building
Philosophy
CPI implementation
Practice or culture change
Medication

Quality Criteria

Yin (2014) supported the use of the logical tests that have been universally accepted in quantitative research as applied to case study research. Yin (2014) identified the tests as "construct validity", "internal validity", "external validity", and "reliability" (p.46). Both statements inform the quality criteria for this dissertation. This study utilized the case study quality critieria of construct validity, external validity, and reliability. Internal validity is not tested in exploratory case studies such as this dissertation (Yin, 2014).

Construct Validity. Construct validity means that the researcher has the correct operational measures identified for the study concept (Yin, 2014). Construct validity demonstrates the objectivity of the case study (Yin, 2014). Multiple sources of evidence were used to demonstrate the objectivity during this qualitative exploratory case study. The use of multiple sources of evidence, including the participants' reviews of transcripts and peer-debriefing were included in the construct validity testing.

The validation of the transcript by the participant provided construct validity demonstrating the common interpretation of the interview between the researcher and participant. The interviews were all validated except for one participant who decided to

withdrawal. Peer-debriefing was used to improve the accuracy of the final themes (Yin, 2014). The peer-debriefing or the review of the emergent theme process for this study included the qualitative committee member reviewing two random interview transcripts and a coded transcript to validate the emergent themes. The researcher and the peer debriefer discussed the independent coding. Both the researcher and the peer-debriefer spent time discussing the meaning of each code so that there was a shared common language. A consensus was met for the final themes.

Other sources of evidence for this study included documentation of leather restraint episodes from the seclusion and restraint use report, psychiatric rapid-response team reports (Code Gray report), and interviews in order to confirm or triangulate data. Code Gray and seculsion and restraint use reports were internal documents available for the researcher's review. The organization's interim director allowed access to the sources of evidence by signing permissions and data use and access permission (Appendix E, Appendix F, and Apendix G). Neither the Code Gray or seclusion and restraint use report contain any specific patient information. The documentation for objectivity does include the restraint information. Archival records include the examination of the Code Event report which is a document kept by the organization to examine the prevalence of hands-on physical hold or leather restraint episodes during a month. This report showed a lack of the use of leather restraints since February 2014. These reports validate the consistency of restraint reduction that the psychiatric-mental health units continues to maintain low to no leather restraint episodes. The use of multiple evidence sources, the participants to review the transcripts, and peer-debriefing were included to meet the construct validity testing. Furthermore the study concepts were clearly defined in chapter 1 for the purpose of a common language and understanding.

External Validity. This quality criterion is the domain that supports studies findings to be generalized or transferred for the use in other settings beyond this study (Yin, 2014). Analytic generalization is the use of logic that extends the findings of this study to similar settings outside of the unit of measurement (Yin, 2014). The concept of transferability means the researcher identifies rich detail to guide readers or other researchers to draw the same conclusions in a similar setting (King & Horrocks, 2010). Generalization is a limited concept in qualitative research (Yin, 2014). There are many discourses regarding generalization in the field of qualitative research. The philosophy for generalization of this study is informed by Yin's (2011) ascertains about analytic generalization. This is a step-wise process (Yin, 2011). The first step involves a conceptual claim that this study's findings are likely to inform a particular of concepts (Yin, 2011). Second is to use the conceptual claim and implicate it towards other similar settings (Yin, 2011). The findings of this study have resulted in future recommendations for study, discussed in chapter 5. Historically, the administrators at the psychiatric-mental health units have publically sought to incorporate a restraint-free environment by making announcements and supporting education toward restraint reduction.

As the data was analyzed the propositions from the psychodynamic nursing metaparadigm were considered, that nursing interventions are beneficial to participants, the interactions between participants and nurses can be studied and understood, there are identifiable phases in a nurse-participant relationship, and that the phases are applicable to all nursing situations (Fawcett, 2005; Peplau, 1952). These propositions guided the interpretation of the data. The use of the validation and the guiding framework demonstrated that analytical generalization or transferability to another psychiatric-mental health facility can be considered.

Credibility is also included within the validity realm and demonstrates how believable the study data is by the confirmation of the interpretation of the qualitative data, confirmed by the study participants, the researcher, and the dissertation committee (Yin, 2011). Credibility was also demonstrated by a chain of evidence that included a study database and field notes that are kept in a password-protected file, indicating the progression of data discovery (Yin, 2014). The believability of the data was evident through the process of member checking. The researcher met with the participant a second time offering him or her the opportunity to review and validate the transcribed interview. The participant signature demonstrated accuracy of the data collected during the interview. The participant had the opportunity to change the transcript or clarify statements which made the data from the participants dependable (Polit & Beck, 2014).

The concept of transferability or generalization means the researcher identifies rich detail to guide readers or other researchers to draw the same conclusions in a similar setting (King and Horrocks, 2010). External validity testing was met through a written and detailed chapter 3, 4, and 5, it is with the precise documentation so that future researchers and nurses can replicate or generalize the findings of this study. Other methods of external validity testing are the existence of theory application and member-checking. The detailed accounts of the participants were written to incorporate thick descriptions so that the reader can evaluate the concepts for incorporation into other similar facilities.

Reliability. Reliability is a demonstration that the results of a study would be the same if the study were repeated (Yin, 2014). One example of the replicable structure of this study was exclusion and inclusion criteria that were identified in the design phase of this study. The demographic form demonstrated the ability to determine that appropriate inclusion and exclusion criteria were reviewed for the sample population (Marshall & Rossman, 2011). By confirming

the research data, the study design should reach the same conclusions (King & Horrocks, 2010). The peer debriefer was able to confirm the reliability of the researcher's final themes. Peer debriefing was a process that took place in a telephone conference. The content of the interviews were coded by each, the researcher and the peer-debriefer prior to the telephone conference. In the conference the coding process was discussed, the commonality of the final themes were discovered. Credibility and confirmability was met in this study was demonstrated through the peer debriefing process (Polit & Beck, 2014).

Reliability to show the consistency of the research approach was demonstrated through the validation of the transcription by the researcher at least three times (Yin, 2014). The researcher listened to the taped interview and compared the typed transcript correcting obvious mistakes (Yin, 2014). The manual codebook (a hardcopy) was used to avoid drift in the meaning of the codes as the data was analyzed. The use of the codebook increased credibility and confirmability of the participant's data (Polit & Beck, 2014). The code was constantly comparing the data with the codes to ensure consistency in assignment of the codes (Yin, 2014). Transferability, consistency, and avoidance of code drifting analysis allows for the results of this study to be transferred to other similar organizations that are seeking expert knowledge in successful restraint reduction or perceptions toward mechanical restraint-free practice. Throughout the next chapters there is detailed accounts which are written using thick descriptions describing the processs of this research so that the study can be replicated.

Assumptions

Assumptions are the relevant factors in a research study (Simon, 2011). One assumption is all psychiatric-mental health nurses have mechanical restraints available as an intervention. The location of the restraints and the type of access available to the nurses accessible by all

nursing staff, was confirmed during the interviews. The second assumption is the psychiatric-mental health nurses would be able to articulate their perceptions of a mechanical restraint process, whether or not they have utilized mechanical restraints as an intervention. This was also confirmed through the articulate interview data transcripts and analysis.

Delimitations

A delimitation is a boundary that has been self-imposed by the researcher which will limit the scope of the study (Lunenburg & Irby, 2008). The boundary that was set for this study included limiting the population to psychiatric-mental health nurses. There are many other team members who work at the psychiatric-mental health units including recovery specialists, therapists, support staff, recreational therapist, and the Chaplain The importance of this delimitation is so the researcher could gain an understanding of the perceptions of psychiatric-mental health nurses to gain new empirical nursing knowledge. The delimitation was confirmed through the completion of the demographic form. Delimitations will be discussed further in Chapter 5.

Limitations

Limitations are the potential weaknesses of the study that are out of the control of the researcher (Simons, 2009). The limitations inherent in this study were (a) historically, the administration of the psychiatric-mental health units being supportive of a restraint-free environment was a limitation. This can affect the staff nurses' behaviors, beliefs, and practices because of the previous influence; (b) case study is a comprehensive review of the unit of analysis or the psychiatric-mental health units where generalizabilty or transferability can be limited to units with the same descriptors; (c) case study method is a subjective method; (d) data that includes self-disclosed information can be skewed by many factors, including memory,

honesty, motivation, and positive or negative reaction to the researcher; (e) the researcher is an employee of the hospital where the psychiatric-mental health units are located and could be viewed as having an opinion that is different than the nurse, and bias could enter the study; and (f) the researcher is a colleague of the participants and has interacted with the psychiatric-mental health nurses, so the interviews may be viewed as social conversation by the participants. Although, the case study design has characteristic flaws, the review of the other types of methods and designs in chapter two determined that an exploratory case study design was the ideal qualitative research design. This relationship between researcher and participants can influence participant responses. Researcher's bias and role are discussed in the next section.

Researcher's Role

The researcher was the instrument for this study. It was virtually impossible to split the researcher from the person who is being researched. As an employee of the psychiatric-mental health units, the researcher had a unique perspective from an insider point of view, understanding the decribed processes and events. The researcher had an outsider view from the nursing staff perspective, she was not bedside nurse at this facility. Through the process of bracketing or reserving subjectivity the researcher attempted to maintain clinical objectivity during the study. Bracketing includes a written description by the researcher related to the answer of the aim of the study (Marshall & Rossman, 2011). The researcher kept a private journal notebook. In order to address ongoing bias, the researcher kept personal notes throughout the collection, analysis, and interpretation phases. Here is an excerpt from the researcher's journal:

> This is a new role for my colleagues and myself. The tape recorder was started. The atmosphere was strange as there were only 2 persons in the room. Rather than staring at the participant, I took notes. I made a concerted effort to remain quiet and not to

contribute as I would in daily conversations with this colleague. The interview guide was used and clarifying questions were asked. An additional clarification was added to the interview guide as well as wording changes, so I can make sure to include that question for all future participants.

Through the journaling and self-reflection a bias was not identified. The committee chairperson would have been notified if bias was identified and not resolved. The self-reflexive activity of keeping a research journal notebook helped to acknowledge awareness by the researcher, which strengthened the integrity of the design.

Human Subject Protections

Approval from the Hospital Institutional Review and University of Phoenix Boards were obtained for protection of the participants (Appendix H). The Hospital Institutional Review Board gave first approval and an exemption was received from the University of Phoenix. Informed consent and confidentiality were handled with the utmost importance in this study. A confidentiality statement was signed between the researcher and the director of the organization (Appendix I). The researcher with an expiration date of October 9th, 2015 (Appendix J) successfully completed the Collaborative Institutional Training Initiative (CITI) human research course.

Informed consent (Appendix K). Participants of the study reviewed the sections of the informed consent form, including the risks and benefits, and had the opportunity to have their questions and concerns addressed by the researcher before beginning the interview (Marczyk, DeMatteo, & Festinger, 2005). Included with the informed consent was an introductory letter explaining the study details and the demographic sheet (Appendix K, Appendix L, & Appendix C). The risks to the participants included a risk for repercussions by the nursing management up

to disciplinary action for voicing serious or contrary concerns. The researcher managed the risk, as she was the only one who had knowledge of the unique identifier and the participant's informed consent and transcript acknowledgement. The benefit for participants was that their perceptions will become a part of future knowledge and practice. The informed consent included written information about the risks and benefits. A copy of the informed consent was given to the participant. The researcher witnessed the informed consent.

Confidentiality. Confidentiality was a component of informed consent. This is an ongoing ethical and legal issue in research. All components of this study remained confidential and anonymous (no identity, no names used). The participants were not named in the qualitative data analysis. The interview recording as well as all other files will be destroyed after three years. The informed consent forms, demographic forms, and transcripts were stored in an electronic locked password-protected file under the supervision of the researcher.

A unique identifier was placed on all study forms and tracked on a separate form once the data analysis was completed. The study forms were scanned and stored in a locked password-protected electronic file. All originals were scanned and stored in electronic, locked, password-protected files. The original forms were shredded upon completion of the study and data analysis. The informed consent did not have the unique identifiers on it and was stored in a separate file within the locked password-protected electronic file. The tracking form was stored in a separate locked password-protected file within the locked password-protected electronic file. The primary researcher is the only person able to identify the above information with the participant. The raw data and taped transcripts will be retained for three years by the researcher in the locked password-protected electronic file with the originals destroyed. Once three years pass, the locked password-protected electronic file will be placed in the trash bin of the

computer, emptied, and therefore, destroyed. If a participant withdrew their information within 24 hours, the raw contributed by the participant was shredded and erased. There was one participant who withdrew her information from the study. The participant withdrew after 24 hours. The data was not included in the data analysis. The data is stored in the password-protected file. The 24-hour time frame created a pause for the participant to decide about their continued involvement in the study. As the informed consents were reviewed, the 24-hour time frame was emphasized for preventing problems with removal from the computer database. The Non-disclosure agreements (Appendix M) were signed for consultation services.

Methodology Summary

This chapter included details related to the dissertation study about the perceptions of psychiatric nurses to the restraint-free trend. The contents include the problem and purpose statement, research question, research method and design, unit of analysis, population, and sample, data collection, data analysis procedures, quality criteria, limitations, delimitations, assumptions, researcher's role, and human subject protection.

Chapter 4

Review of Findings

The purpose of this exploratory qualitative case study was to obtain the perspectives from the psychiatric-mental clinical nursing staff related to understanding the facilitators and barriers to a restraint-free practice. In a case study design it is important to provide evidence that the unit of analysis or the case continues to be an exemplary site so that the research study continues to be in a case study methodology. The evidence is addressed within the discussion of the protocol questions. The evolutions of the barrier and facilitator themes are discussed in the following the proof of evidence. The theme of barriers include current practice, medication, and patient acuity or behavior. The themes of facilitators are philosophy, CPI implementation, practice or culture change, and medication. This chapter will include a description of the research participants, demographics, findings, and a summary.

Profile of the Participants

The original sample size was thirteen participants. The inclusion criteria for the participants of the study were (a) current registered nurse practicing in Nebraska; (b) working in the inpatient psychiatric unit (unit of analysis); and (c) at least 1 year of experience working as a psychiatric-mental health nurse. The inclusion criteria were confirmed by reported employment status on the demographic form, as well as the researcher's personal knowledge of the participant's employment status. Exclusion criteria included less than one year of experience as a psychiatric-mental health nurse and working outside the psychiatric-mental health units. All of the inclusion criteria were met for the thirteen original participants. One participant asked to be withdrawn after the data collection phase was completed. Although the request for withdrawal

from the study was after the stated twenty-four hours within the informed consent, the researcher was able to accommodate the withdrawal request.

As illustrated by Figure 2, the average number of years for total nursing experience was 9.8 for all of the included participants, as a psychiatric-mental health nurse, 8 years, and as a psychiatric nurse at the psychiatric-mental health units for 6.75 years.

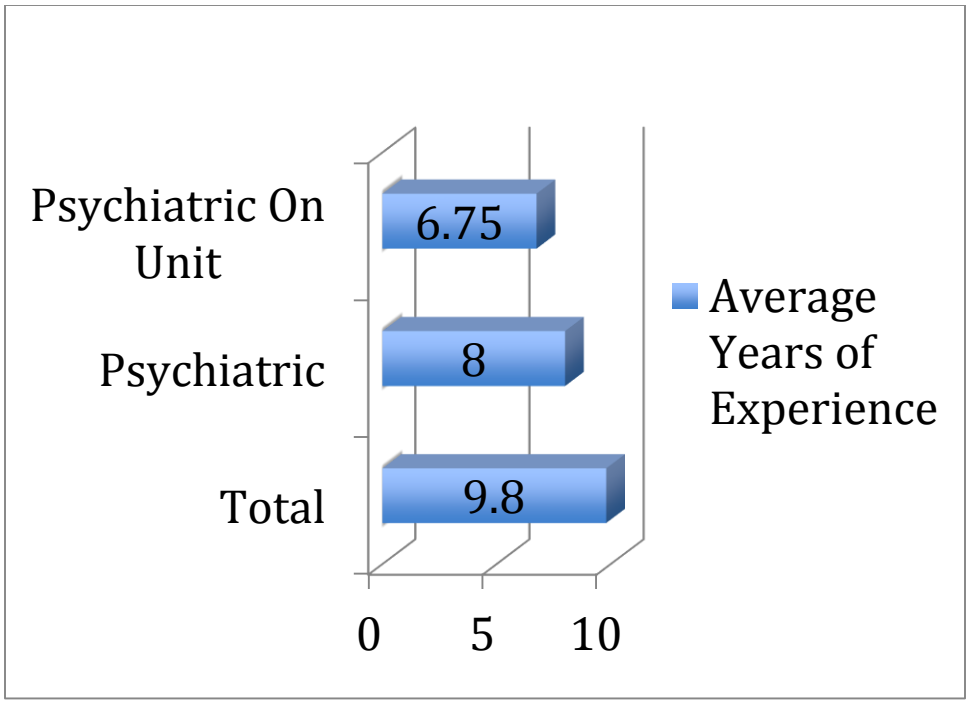

Figure 2. Average Years of Experience

All the participants were permanent employees of the organization. The organization is a large hospital in the Midwest. There are two psychiatric units, which have 45 beds combined. The participants are typically assigned to one unit; however, they have been cross-trained for the other unit. Of the twelve participants, seven were full-time or 58% and five were part-time or 42% (see Figure 3).

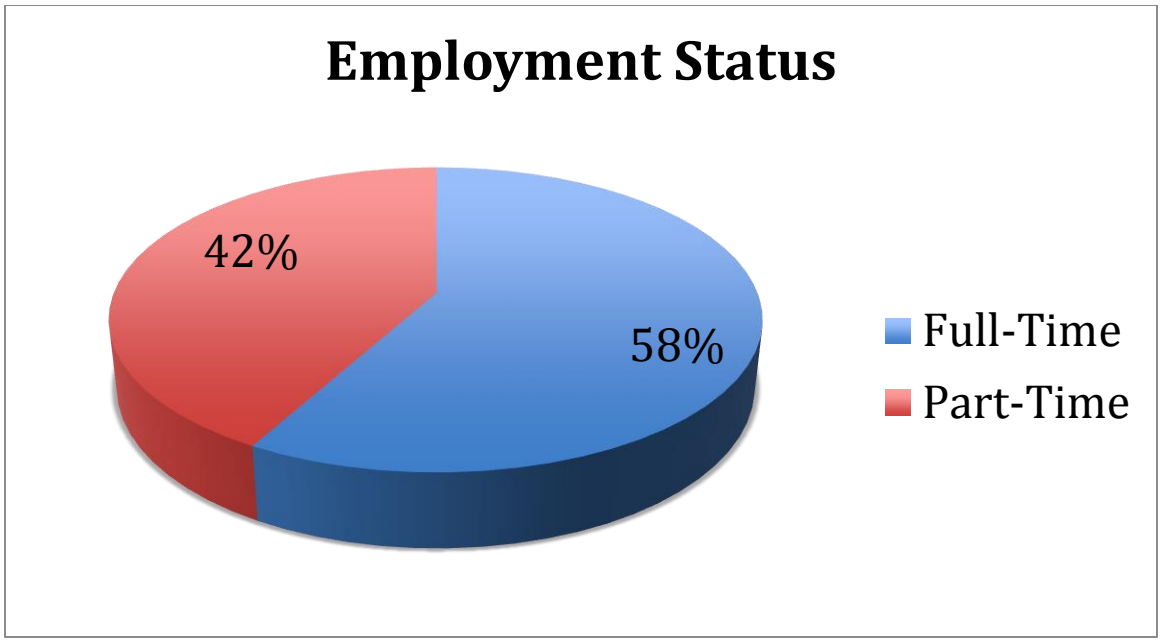

Figure 3. Employment Status of Participants

The educational levels included Associate Degree (42%) (AD), Bachelors of Science in Nursing (BSN) (42%), and Other Bachelors (16%) (see Figure 4). The educational level of Registered Nurses in the United States with a bachelor's degree is 44.6% and with an Associate Degree is 37.9% (Health Resources and Services Administration Bureau of Health Professions National Center for Health Workforce Analysis [HRSA], 2013). The combination of the participants with a BSN (42%) and with other bachelor's degree (16%) was at 60%, and participants having an AD at 42%, the average formal education of the participants was noted to be higher than those of the average population of the nursing workforce (HRSA, 2013).

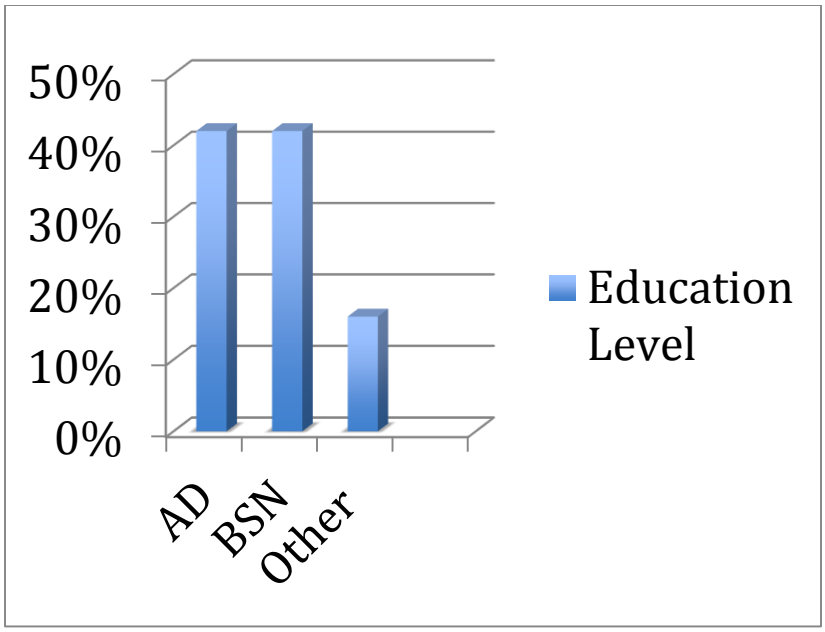

Figure 4. Educational Level of Participants

Lastly, the age ranges of the participants include 20-29 (8%), 30-39 (25%), 40-49 (17%), 50-59 (33%), and 60 + (17%) (see Figure 5).

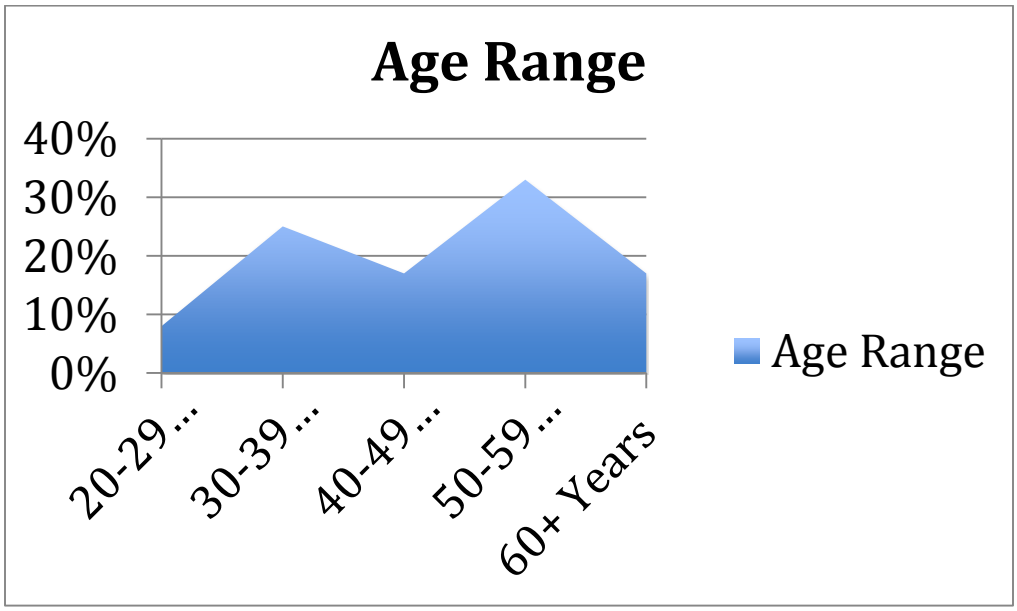

Figure 5. Age Range Dispersion of Participants

Findings Review

The analysis process included the use of NVivo, the qualitative research computerized software. The interviews with the participants were audio digitally recorded and then transcribed by the researcher. The transcriptions were imported into the NVivo software program. The analytical memos and journal notes were also imported into the software program. Each transcript was carefully reviewed and the ongoing coding process continued through the multiple cycles. Structural analysis was used to organize the large amount of information from each interview and focused on the research question: How has the reduction of mechanical restraints on the psychiatric-mental health units impacted the practice culture? Structural coding is the process of taking larger segments of data and categorizing into smaller segments in a cyclical manner until the final iteration of coding revealed the final themes (Saldana, 2013).

To improve the accuracy of the final themes a peer-debriefer, reviewed two transcripts and coded those transcripts to validate the final themes. The peer-debriefer was one of the researcher's committee members, who is a qualitative researcher. She reviewed and coded two transcripts to confirm the themes of this study. Discussions were held with the researcher and peer-debriefer. The peer-debriefer and the researcher spent time discussing coding strategies and compared their independent coding. The comparison led to a consensus and validation of the final themes between the researcher and peer-debriefer. The barriers and facilitators of mechanical restraint reduction emerged. The barrier themes are current practice, medication, patient acuity or behavior. The facilitator themes are philosophy, CPI implementation, practice or culture change, and medication.

During the final coding cycle the researcher realized that the data from the protocol questions were emerging as large categories and would offer a deeper understanding of the

perceptions of each nurse toward a restraint-free practice. This realization lead to the discovery that the data from the questions not only held themes but held evidence about the psychiatric-mental health units that needed to be reported. The research question: how has the reduction of mechanical restraints on the psychiatric-mental health units impacted the practice culture and the research sub question: what are the perceptions of the psychiatric nurses toward a mechanical restraint-free practice are the focus of the research findings. Each of the protocol questions was designed to gain knowledge toward the research question and sub question. These important areas of evidence support the significance of this case study. The significant evidence from the case study include reduction of mechanical restraints, the nursing role, how decisions are made, the participants description of a time when a patient was in leather restraints, the perception regarding the move of the leather restraints off unit, and the perception related to an adoption of a mechanical restraint-free practice. The protocol questions that informed but did not limit the evidence were (a) how has the reduction of mechanical restraints changed your practice and the practice of the others on your units; (b) what has been your role with homicidal or suicidal psychiatric patients and use of restraints; (c) describe a time when a patient was placed in mechanical restraint; (d) if your unit were to adopt the mechanical restraint-free trend, what would be your thoughts and feelings regarding the change; (e) what would it take to go restraint-free; (f) how has the move of the leather restraints to the off unit utility room made a difference in practice; and (g) what additional thoughts do you have regarding going mechanical restraint-free at the hospital?

The themes from this study evolved from the responses of the participants from all of the protocol questions. The barrier themes which limit the removal of the restraints out of the facility are current practice, medication, patient acuity or behavior. Current practice is described

as the experience of the current staff and the time it takes to de-escalate a patient. Medication was identified a barrier when the medication that was given does not work as expected or is not effective on the target behaviors of the patient. Patient acuity or behavior is described as patients having a high acuity or need for care and the extreme behaviors of patients. The facilitator themes which can support the movement toward a restraint-free practice are philosophy, CPI implementation, practice or culture change, and medication. Trauma-informed care, individualized care, and a supportive administration are the elements of the units' philosophy as described by the participants. CPI is a de-escalation program that was thought to be a positive change for the units. Practice or culture change is that staff were empowered to intervene with patient's earlier to avoid an escalation in the patient's behavior. The evidence and themes are discussed below.

Evidence: Reduction. The protocol question: how has the reduction of mechanical restraints changed your practice and the practice of the others on your unit, confirmed that the nurses believed that there was a reduction. The first level quotes that emerged from the protocol questions are presented. All the participants except one (employed at the psychiatric-mental health units for 18 months) noted a decrease in the use of leather restraints. According to the psychiatric-mental health units' restraint use documentation, the use of leather restraints had shown a reduction over a period of seven years. The department report indicated that there were twenty-nine mechanical restraint episodes in fiscal year 2008 to one episode in fiscal year 2014 and to date in 2015. The voices that support the decrease in the use of mechanical restraints ranged from comments about the length of time since their use, "it's been a long time since I was involved in mechanical restraints at all," "I mean, we not using them that much anymore," "like I said we haven't used em," " I did not think we were doing it much then, but we are definitely

doing it less now" and the amount, "less and less, yes, yes," "I feel it is a big reduction," and the quality "we are as hands-off as we can be" and "really significantly. Based on the responses of the participants, it would appear that restraints are being used less and the reliance on restraints is minimizing.

Evidence: Nursing Role. The participant role of the registered nurse in regard to the protocol question: what has been your role with homicidal or suicidal psychiatric patients and use of restraints, was described through the identification of nursing duties by the participants. The first level quotes that emerged from the protocol questions are presented. The participants emphasized the complexity of psychiatric mental health nursing role, one participant stated:

> My role starts out with…giving their regular scheduled meds if they will take…talking to them calmly, if I know there's a certain staff member that they will work really, really well with that's the staff member I assign them…I offer them a PRN [pro re nata or as needed medication], we give them things to do, we give them space, we maybe let them go out in the courtyard and throw the ball around. Or do something to kind of help to get rid of some of that anger and stuff.

This participant has worked on the units for at least five years and has provided support and patience from an empathetic perspective. The participant illustrates the care and patience necessary to avoid using mechanical restraints. The nurse is an integral part of the patient's recovery in this acute care setting, "WRAP is a big part of our program," giving them some power to make decisiona and changes in their treatment, you know having them be part of the treatment team," and "giving the power to calm themselves down." The use of the Wellness Recovery Action Plan or WRAP is a strategy that is developed by the patient with the assistance of the psychiatric-mental health unit staff. The WRAP plan includes identification of triggers,

warning signs, and individualized coping skill development. The nursing role that was described by the participants included a focus on wellness and recovery as treatment concepts within the patient WRAP plan process. “I go over that [WRAP] all of the time in my nursing groups,” identifying “triggers, coping skills,” and offering “coping skills groups” are statements from nurses that focus the patient toward health, wellness, and recovery.

The participants described keeping the patient safe from harm as the main role for the psychiatric-mental health nurse, this category also included the safety of staff members. The nurse could call the police for critical assistance, when the clinical situation was not manageable in a crisis situation. “To keep staff safe and usually the police are called,” “we end up calling the police,” “so then we would have the police involved,” and “I think at that point the police handle it.” The police call for assistance is an urgent safety situation. The nurses who discuss the calling of the police describe this as a patient event that could not be handled by the staff.

Other safety responsibilities monitored by the nurse for the participants were obtaining orders and the decision to use restraints. Orders are taken via the telephone from the psychiatrist “frequently we do have to call, to make an order or to obtain an order, so that we have something …, a medication” and “ somebody have to get the order.” The orders that the nurses are obtaining for safety situations on the unit include medication and seclusion, physical hold, or restraint orders. The decision to use leather restraints was described as part of the participants’ safety role. It is a difficult decision as supported by these statements, “I look at it more like a safety than a restraint,” the restraint is “done for safety reasons,” if a patient is “suicidal or homicidal, aggressive …danger to themselves or others,” and “deciding when to put our hands on them if we need to.” Based on the responses from the participants safety was seen as an important role for the psychiatric-mental health nurse.

The nurses' role characteristic for care delivery was catagorized as individualization or patient centered-care. The nurses described multiple ways to assist a patient who is struggling with psychiatric-mental health issues to meet their needs. Meeting the needs of the patients was described as allowing for patient "space," "de-escalation," "medications," selective patient "assignments," "communication," "comfort rooms," as well as the development and support of the "WRAP [Wellness Recovery Action Plan]." It was through the participants plentiful and caring descriptions that the individualization or patient-centered care was identified a priority.

Evidence: Decision Making. The decision to use leather restraints was discussed throughout the interviews and protocol questions. The first level quotes that emerged from the protocol questions are presented. The decision to use physical holds was specifically addressed at times; however, the focus of this study is leather restraints. Yet, the researcher recognizes that the decision-making process for a physical hold or leather restraint can be similar. So unless the data was exclusive to a physical hold process, the participants' data was included in this section of evidence. The clinical presentation of the psychiatric-mental health patient may include a physical hold, which is a least restrictive intervention when looking at the restraint application decision-making continuum for nurses. The choice to use leather restraints was considered a major decision and responsibility by the participant nurses, "it's my responsibility to make sure that's okay," "if that physical hold was unable to make a change or make a difference or the patient was unable to respond favorably, that's when I think…the actual leather restraints would be used" and it is "kind of nice to say that if we were going to use them it would be a major decision." These quotes confirm that the nurses believed that the use of leather restraints was a major decision in their nursing practice.

Typically, the participants could see the lack of clinical improvement of the patient condition as the least restrictive measures failed prior to the implementation of leather restraints, the participant describes, that they are "not going to let the patient hurt themselves" and "we had exhausted absolutely every option we had." Examples from the participants of the least restrictive measures included verbal "de-escalation," "medication," or "physical holding." The participants reported that the decision to use leather restraints related to the "patient safety," a "danger" to themselves or danger…others," such as the patient being unable to "calm" themselves or "staff physically tired of holding the patient." The major decision to use leather restraints was perceived by the participants to be a mutual decision by the Registered Nurse and the Registered Nurse in a leadership role, such as "house supervisor" or "house manager." These statements regarding the failure of clinical improvement, least restrictive measures, understanding of patient and other safety, and that the decision to use restraints was a mutual decision by two nurses continue to describe the complexity of the decision-making for the psychiatric-mental health nurses.

Overall, the clinical staff avoided the use of leather restraints, the reasons were identified related to safety and to avoid "trauma" to the patient, "we don't like to go hands-on," leather restraints are consider a "last resort" patient intervention, and staff feel like the use of restraints is a "failure." Participants also consider the decision to restrain patients an event that is stressful for the staff. At one point a participant described the clinical staff as "angry" for the decision to place the patient in restraints because it was considered a "culture shock" for those staff who have had minimal if any involvement in the leather restraint process beyond the restraint and de-escalation competency training. The participant comments regarding leather restraint include that the event "was more traumatic on staff than I ever thought it would be" and "staff would rather

not put a restraint on again in their lifetime, if they didn't have to," underscores the stress on the staff. The comments by the participants describe the strides the nurses use to avoid the use of leather restraints.

Evidence: Description of a Time Involved in Leather Restraint. The protocol question: describe a time when a patient was placed in mechanical restraints, generally informed this section of evidence. The first level quotes that emerged from the protocol questions are presented. Each of the twelve participants had training in restraint application. The psychiatric-mental health units' leadership recognizes that the use of restraints is a high-risk and low-volume event and provides a yearly competency testing to each of the clinical staff. Of note is that the formalized de-escalation education (CPI) occurs at a different time than the competency for leather restraints. The significance of this separation is to emphasize the importance of the de-escalation without association with restraint usage.

When the participants were asked for a description of a restraint event from their perspective, two participants had difficulty recalling the specifics of the past event. The participants paused and expressed difficulty in remembering; one stated, "can't recall who it was. I am having a hard time recalling." They took time to search their memory, then shared their stories. Three of the participants had never been a part of a restraint process. One participant had been a psychiatric-mental health nurse for eleven years and "couldn't picture myself ever doing that," the second participant mentioned "I've, never had to use restraints, but I have only been here for a year and a half," and the third participant responded " I have never had to use restraints," the third participant has been a psychiatric-mental health nurse for approximately two years. Given that the leather restraint use is minimal on the psychiatric-mental health units, newer clinical team members has not been involved in a patient leather restraint event. The

comments from the participants about their experiences from a past restraint event or not allowed the researcher to understand the experience of each of the participants.

Seven participants described the following regarding a restraint event. The patients were described as "uncontrollable," " we just couldn't get the situation under control," the patient was "violent," there was "self-harming," and the patient "unable to contract for safety." One event included a perceived unending amount of physical holding that put the patient and staff at risk for harm, so the decision to use leather restraints was made, "you can't let your staff get so physically tired that they can't keep the patients safe." Based on these quotes, the unpreditable nature of the restraint event for the nurse is very clear.

Although the leadership of the psychiatric-mental health units offer training and practice toward de-escalation, physical holding, and application of leather restraints "it [the process of leather restraints] never works like you practice it." In fact, staff described the event (or physical holding) as "adreneline high." The staff work as a team to double check each other for appropriate therapeutic behavior during the restraint event to ensure the "adrenal high" does not interfere with the correct application of the restraints. This critical team responsibility is described as staff needing to understand their own emotions during a restraint event so that the experience is kept as objective as possible. One nurse who said "a youth patient, who makes it harder for me, I guess it is when my mom instincts kick in" describes the impact of the restraint event on staff. The comments from the participants continue to describe the complexity of a restraint event.

If the nurse decides to apply the mechanical restraint, the participants describe nursing assessments such as checking for injuries, and ongoing monitoring of the patient "making sure their vitals are stable, that they've got food…fluids and …thing, you know if there is anything

else going on with them." One participant describes assessing the protection of "human dignity," which included the potential psychological trauma, especially "retraumatization," if the patient has had a history of sexual trauma or any other relevant trauma history, "we have to be real careful because people have been traumatized especially the sexually abused ones." The participant recalls an event where "retraumatization" was minimized through considerate nursing interventions such as covering the patient if their clothing had shifted, "I said we need a blanket covering her because her shirt was up and she had twisted so much." Consideration of the patient's viewpoint of the restraint process was critical during the leather restraint process. After, the patient has reached the criteria for the removal of the restraints, such as speaking coherently or not striking out at staff, the restraints were removed in a rotating fashion starting with the non-dominant limbs, "we just removed them in the order that we are suppose to." The patient is continually assessed during the leather restraint process, during, and in the immediate post restraint period for signs of escalation or injury. These comments demonstrate the nursing interventions considered during a restraint episode.

Evidence: Leather Restraints off the Psychiatric-Mental Health Units. The protocol question: how has the move of the leather restraints to the off unit utility room made a difference in practice, informed this section of evidence. The first level quotes that emerged from the protocol questions. The leather restraints kept on each of the units in a storage area just off the seclusion and restraint rooms. Each unit has two restraint rooms. Approximately 6 months ago, the leather restraints moved to a centralized storage room off the units. The formal seclusion and restraint rooms called the quiet rooms. One of the two restraint rooms on each unit transformed into a "comfort room" while the other continues to be available in the event of a seclusion or restraint. The participants employed at the hospital at the time of the "comfort room"

implementation and leather restraint removal off the psychiatric-mental health units' transition. The practice change questions were asked of each participant. The question framed as: how has the move of the leather restraints to the off unit, utility room made a difference in practice? All of the participants stated that there had not been a noticeable practice change with the restraints being moved off of the units to the centralized location, including comments such as, "I really don't think it [moving the restraints] had made a difference one way or the other," "so during that hold piece, that staff can go across the hall to where the restraints are kept and get them if they anticipate needing them," and "no, not really, I mean when they were on the unit, we did not use them anyway." The leather restraints are still accessible, and the move reinforced the time for assessment for the use of the leather restraints and reinforced that the use of the leather restraints is a major nursing decision, one participant states, "it [moving the restraints] reinforces your staff that CPI is the way we want to go." One participant did voice hesitancy about the restraints being off the unit. That participant observed that if a patient was a harm to him or herself or someone else to the degree that the restraints are needed all persons would need to be on the unit to assist in keeping the patient and others safe and posed the question, "who would go get them?" These statements illustrate that the movement of the leather restraints off the unit had no impact on nursing practice.

Evidence: Adoption of a Mechanical Restraint-Free Practice. The participant's response regarding the adoption of a mechanical restraint-free unit informed this section of evidence. The first level quotes that emerged from the protocol questions are presented. The questions: if your unit were to adopt the mechanical restraint-free trend, what would be your thoughts and feelings regarding the change and what would it take to go restraint-free? n

In order to understand the perceptions of the nurses and the removal of the restraints from the building, they were asked the question, what would take for the unit to become restraint-free. The responses were varied. Three participants thought that the use of seclusion would need to increase "I would be more in favor of seclusion, than physical restraints;" however, self-harming behaviors could become an issue, such as "self-trauma" for example, "run into the wall repeatedly or bang their heads." Others stated more "verbal de-escalation" and continued individualization of care techniques that focus on avoiding "demoralizing the patient" and "retraumatizing" the patient needs to be a priority for the movement toward restraint-free practice. Still others mentioned the use of medication would need to be evaluated "for 6 days the Zyprexa wasn't holding him or wasn't even taken the edge off," including exploring the definition of chemical restraint "if you take away the physical restraints are you going to be relying more on chemical restraints?" Four of the participants had a does not know type of response including "I honestly don't know," "don't know if I would want to go that far," and "I don't know." The comments from the participants are mixed indicating that there is not a united thought that could move these psychiatric-mental health units toward a restraint-free practice.

Theme: Barriers Towards a Restraint-Free Practice. The participants discussed the challenges of restraint reduction and the moving the leather restraints out of the building. The first level quotes that emerged from the protocol questions are presented. The protocol questions were designed to understand the barrier towards the removal of restraints out of the psychiatric-mental health units. The first level quotes that emerged from the protocol questions are presented. The barriers that emerged were current practice, medication, and patient acuity or behavior.

Current practice. The perceptions of current practice that would prevent the complete removal of the restraints out of the building include the experience of the staff and time constraints of the staff when needing to de-escalate patient episodes. A couple of participants indicated the skills of the staff; one stating it would "make a difference who's working." The participants reported that the staff experience on the unit is an important factor on the psychiatric-mental health units. For example with staffing and patient assignments, "if I know there's a certain staff member that they work really, really well with. That's the staff member I assign them to." The comments from the nurses describe the varying skills of the staff.

Time constraints are a barrier toward a restraint-free practice. The participants report "I think it was just the practice on how we were addressing things" and "good communication with staff…that whole de-escalation process is key, recognizing what's going on. Getting them going, …so you know hopefully, and sometimes it requires a medication." This individualized care process is "staff intensive" and generally takes staff away from the staffing that is already assigned to the units. The de-escalation of a patient psychiatric-mental health patient crisis does not have an estimated time. The participants described "so it takes some time," "we spend a lot more time talking, calming, processing, with them," " we give them some time. We give, talk to them calmly and we try to give them a choice, if we can," "spend time with patients," "take more time, they process better," and one participant discussing the number of persons who can be assigned to a unit "you can't staff heavy all of the time" as these crisis events are unpredictable. Based on these quotes from the participants time is an important consideration when working with psychiatric-mental health patients.

Medication. Medication is often used as a least restrictive measure; however, some participants have found the unpredictability of the medication or the lack of effectiveness of the

medication on the target behaviors during an inpatient psychiatric-mental health crisis is a barrier for the removal of restraints from the building. One participant described the lack of predictability or control of medications as compared to restraints, "I view chemical restraints the same as physical restraints…you cannot control it as much as the physical restraint." Once the medication is administered "you cannot predict when it [medications] will wear off as the effect is different for each patient" and "I mean it is like taking vitamins. It [medications] just does not work," and "it [medications] was not effective." The comments and helplessness of the nursing staff with the unpredictability and effectiveness of medications is a barrier to the removal of the restraints from the building.

Patient Acuity or Behavior. The study participants have identified the high patient acuity and extreme behaviors as a barrier for the removal of restraints out of the building. This theme was carried throughout the interview questions. These extreme patients are described as "really acute," "so psychotic," "really, really sick," "no reasoning," "violent," "completely out of control," or severely "impaired." Some of these patients were deemed questionable admissions that had unknown symptoms prior to presentation at the facility, including extremely violent behavior, "sometimes we get people that are little more impaired…then we are able to handle." The comments emphasize the high acuity and extreme behaviors of some of the psychiatric-mental health patients.

Theme: Facilitators Towards a Restraint-Free Practice. The participants discussed the particulars of the successes of restraint reduction. The protocol questions were designed to understand the facilitators towards the removal of restraints out of the psychiatric-mental health units. The first level quotes that emerged from the protocol questions are presented. The theme

of the facilitators includes philosophy, CPI implementation, practice or culture change, and medication use.

Philosophy. As the participants interacted with the interviewer through all of the interview questions, the philosophy of the psychiatric-mental health nurses' emerged, that included trauma informed care, individualized care, and a supportive administration. "Trauma informed care" is a heightened awareness by the clinical staff at the psychiatric-mental heath units that there is trauma in the patient's background. Sensitivity to the patient and their experience (current and past) was a primary philosophy, the staff tries to be "respectful of their human dignity." The individualization of care evaluates the patient regarding their needs in their situation, for example participants identified helping the patient identify "triggers, coping skills, I go over them all of the time in my nursing groups," "number one thing is focus on tuning into the patients recognizing their nonverbals, listening to them, be part of the treatment team, they come in and talk everyday, so everybody is on the same page," and "we can intercept negative behaviors, …before they get out of hand, giving the patient the power to calm themselves down." Staff focus on understanding the patient and have noted that the patient doesn't "get so mad because they feel threatened" when the nurse come from a "place of curiosity...rather than criticism or judgment." The participants indicated several examples on how to individualize care, including: use of the "comfort room," "caring rounds," "processing" with the patient their feelings and behaviors to identify opportunities for improvement, careful selection of staff to patient "assignments," "clear communication," "weighted blankets," and the "Wellness Recovery Action Plans [WRAP]." The participants noted that trama informed care and individualization are an important part of how the psychiatric-mental health units work together in caring for the patients.

The leadership for the psychiatric-mental health units was thought to be supportive, including the director and the medical director. The director had "a different way of thinking" and she was a "nurse" that added to the success of the restraint reduction as compared to the individuals who had a degree solely in administration. The medical director was described as "a consistent force…very stable, very open" that contributed to the restraint reduction by supporting staff, providing education, and setting limits on the use of restraints. The comments by the participants demonstrate that leadership has shown a difference in supporting the philosphy toward restraint reduction

CPI implementation. CPI training was implemented throughout the psychiatric-mental health units in October of 2012; all participants are trained in this program. The move to the CPI program was determined to be a positive move for the psychiatric-mental health units as the participants report the CPI program "reinforces the way we want to go" is "workable with the people, with staff," "everybody with their CPI training; people are more apt to talk," and "I think CPI is much better." The comparison to the previous program is that the clinical staff is taking more time "they will take more time, they, they process better, and…if we do have to take any kind of…action, their CPI is just much better" and they "process better" with the patients. Staff is having positive experiences with the CPI techniques and believed that the previous program "was too instantaneous." CPI implementation has been identified as a theme by the participants for the facilitation of restraint reduction.

Practice or culture change. The practice or culture change is that staff are empowered to intervene with early identification of escalating behaviors. When a patient is starting to escalate the unit staff work with the patient with the least restrictive alternative ("de-escalation," "comfort rooms," or "weighted blankets" and stand ready to use physical holding, seclusion, or leather

restraint to assist the patient in reducing their heightened state. One participant said "it [CPI] has empowered staff to be more interactive and to say I see your kind of pacing, what can I do for you, what do you need? You know, instead of just watching and watching." The interventions include the use of "verbal de-escalation" techniques. The de-escalation techniques were identified by the participants were verbal interaction with the goal of intervening early, allowing "space" for the patient to "process" or vent, and feeling (for example, "anger") reduction, through individualize coping strategies, such as "self-soothing." The objective of de-escalation is "try to get to get them calm to the point were we don't have to do any kind of restraining" and "not let it progress maybe so far sometimes." Of note is the idea that staff are "empowered to be more interactive" and to intervene or de-escalate with the patients early to avoid extreme behaviors, such as self-harm or harm to others. Staff is more aware of the signs and symptoms that patients can exhibit prior to exhibition of extreme behaviors. Staff is "a lot more vigilant regarding nonverbals and regarding ways we can intercept negative behaviors." Beliefs, perceptions, and practices can allow or stop a change in culture. One participant described a culture change from when she started at the psychiatric-mental health units "it seems like when I started that some of the staff were like you know we need to do this physical hold, we need to get this med in them. And now it's more of a culture change where they are not saying that." Based on these statements the practice or culture change is related to the empowerment of staff to affect the practice or culture change.

Medication. Medication use was also a facilitator for the psychiatric-mental health units. The participants indicated that the staff are assessing for the "sometime" use of PRN medications to "calm them [patient]." The goal is to decrease the indicated symptoms, such as being "totally out of control and would not calm," "violent" or "self-harming." "PRN" medications are

typically available; however, more recently "I think that we're being faster on applying medications or offering medications that are needed, and using enough medication to help the patient." These comments support the theme of medication use as a facilitator toward a restraint-free practice.

Review of Findings Summary

The results of this study have provided new knowledge for the psychiatric-mental health nurses. The case study relevance evidence was demonstrated through the unfolding of unique knowledge from the interviews. The barrier themes of current practice, medications, and patient acuity and facilitator themes of philosophy, CPI implementation, practice or culture change, and medications toward a restraint-free practice were identified and discussed.

Chapter 5

Discussion and Study Summary

The purpose of this qualitative exploratory case was to gain an understanding of nurses' perceptions regarding a restraint-free practice and to identify the facilitators and barriers toward a restraint-free practice. The conclusions from this study followed the research question, how has the reduction of mechanical restraints on the psychiatric-mental health units impacted the practice culture, with the sub question of what are the perceptions of the psychiatric nurses toward a mechanical restraint-free practice? The findings and conclusions therefore address the evidence review from the protocol questions and the identified thematic results of barriers and

facilitators. Following is a discussion of the evidence, major thematic findings with conclusions drawn from this research study, and recommendations for future study with a final reflection of the study.

Theoretical Context

The data analysis and interpretation was guided by the propositions from the Psychodynamic Nursing metaparadigm. As the data was analyzed the propositions from the Psychodynamic Nursing metaparadigm were considered including that nursing interventions are beneficial, the interactions between participants and nurses can be studied and understood, there are identifiable phases in the a nurse-participant relationship, and that the phases are applicable to all nursing situations (Fawcett, 2005; Peplau, 1952). The theoretical framework for this study provided the logical structure for linking the findings to the body of nursing knowledge. The theoretical framework for the study was drawn from three distinct nursing models: Peplau's psychodynamic nursing (also known as interpersonal relations in nursing), Watson's human caring, and Roy's adaptation theory (See Figure 1). This theoretical context was a good fit for this qualitative case study because the importance of the interactions between the researcher and participant is critical to gain the perceptions of the nurse toward a restraint-free practice.

The theorectical framework was used as a lens to assist in emerging each of the findings. In the analysis phases the participants' responses went through the thematic coding process where there was a beginning phase or the orientation phase. Then, as the themes emerged, there was a working phase in which the themes were refined and a final phase or the termination of the coding process. The coding process was an iterative process that included moving in and out of the orientation, working, and termination phases of the theorectical framework. The researcher used the framework to reorganize the themes by understanding that the use of adaptations and

caring moments noted by the participant's voice regarding the patients to move the comments and statements into final themes and findings.

In the future, the themes of facilitators and barriers can become a part of this moving theorectical framework. The facilitatiors and barriers inform psychiatric-mental health nursing practice. The orientation of the facilitators and barriers are now understood by those that read this new evidence. As the facilitators and barriers are considered by other facilities there will be a working phase of this knowledge in more facilities. At the same time, the use of caring moments and adaptation allow for adjustments by those who will apply this knowledge.

In tying the findings to the nursing body of knowledge the theoretical framework is significant. The evidence from the protocol questions and the emerged themes are a part of the caring moments and the adaptations that influence the nurse-to-patient connection, as the nurse and patient work through the orientation, working, and termination phases in their relationship. The evidence includes both caring moment effects and adaptation opportunities. It is through understanding the themes of the caring moment effects as facilitators and adaptation opportunities as barriers that affect or surround the nurse-patient relationship. As the nurse understands and applies the new knowledge of evidence, facilitators, and barriers, further caring moments or adaptations can develop.

Evidence: Reduction

The protocol question where the reduction evidence was found was: how has the reduction of mechanical restraints changed your practice and the practice of the others on your units? The perceptions of the majority of the nurses noted a reduction in the use of restraints. The reduction was also supported in the documentation of restraint episodes from the psychiatric-mental health units. The psychiatric-mental health units and participants have been

working on restraint reduction for at least thirteen years. The impetus for change came from regulatory agencies and leadership. The fact that the reduction was initiated by regulatory agencies is in line with the literature related to the idea that restraint reductions are ultimately the result of the efforts to reduce restraints by regulatory agencies and policies (Glezer & Brendel, 2010). Successes related to restraint reduction have been aligned with the demand for a decrease of restraints (Goetz & Taylor, 2012). The nurses at the psychiatric-mental health units through the influence of the regulatory agencies have successfully decreased the use of restraints over the last seven years. This can be described as a caring moment effect.

The significance of the finding of a reduction in the number of the leather restraints over the past seven years shows that the psychiatric-mental health units is demonstrating compliance with the demand for the restraint reduction by governing bodies and leadership. These adaptative findings add to the body of nursing knowledge related to restraint reduction. A significant finding includes that the staff are passionate (theorectical caring moment) about not using restraints within their practice. The implications are that the psychiatric-mental health units have a culture that would support continued reduction of restraints through the confirmed reduction of restraints and the ongoing compliance with governing bodies' restraint reduction.

Evidence: Nursing Role

The nursing role evidence findings were primarily from the protocol question: what has been your role with homicidal or suicidal psychiatric patients and the use of restraints? These findings include that nurses have a complex role within an inpatient acute care setting, keeping the patient safe from harm is the main role of the nurse, and individualized or patient centered care is the model used by the nurses for care delivery. The comparision of these themes to the literature is discussed below.

The literature offered support to the complexity of the roles that the participants identified including communication and preparing medication (Silvana, Laura, Ursula, Irene, & Paolo, 2012). In an occupational research study using a case study method on a psychiatric unit, these roles and complex duties of the psychiatric nurse were validated (Silvana et al., 2012). The participants of the current study identified medictions, obtaining order, safety, and decision-making as a part of the complexity in the role of nursing. The duties from Silvana et al. (2012) included shift reports, preparing and administrating medication, and prevention of suicide and self-destructive behaviors. These multifaceted roles demonstrate caring moment effect prospects.

The participants' reports indicated that there was a primary nursing duty to keep the patients and others safe on the units. Related to safety in the literature it was found that nurses needed to accept that while working on psychiatric units: the units are locked, there is a possibility of restraint use, existence of a high aggression environment, and a lack of resources (Silvana et al., 2012: Lai, 2007; Larue et al., 2009: Roffe et al., 2007). Consistent with the results of this study, patient safety was the focus of the complex psychiatric-mental health-nursing role. The nurses have theoretical adaptation opportunities to keep patients safe.

The police are an essential community partner for minimizing risk for patients and others (Laing, Halsey, Donohue, Newman, & Cashin, 2009). The participants mentioned the police as a collaborative partner when the participants were not able to de-escalate a patient. The steps taken by the participants to keep the participants from going into restraints included de-escalation techniques such as verbal discussions, limit setting, gaining orders for medications, and giving medications. Koukia et al. (2009) indicate that psychiatric-mental health nurses are in a key role in the management of psychiatric incidents. This information began to emerge when

the participants noted the involvement in recovery-oriented practices, such as the WRAP process and de-escalation management (Caring moment effect).

The complexity of the nursing role was identified by the partcipants, as all areas of safety and personal awareness factors that keep the inpatient unit safe. Awareness of interactions, interpersonal style, and bias by the nurse regarding the role of aggression and safety, are addressed in the literature. There was information from the participants that mentioned interpersonal style, awareness, and bias, which would be an area for futuristic study. The maintenance of patient and staff safety is consistent with the literature describing the use of nursing assessment skills, observation of the milieu, and critical thinking, to discover early escalating patient behaviors (Jayaram, Samuels, & Konrad, 2012; Keltner et al., 2007; O'Brien & Cole, 2004). These are caring moment opportunities.

The participants frequently discussed the individualization or patient centered care concepts. These interventions include choosing nurse to patient assignments, communication, comfort rooms, and allowing for space. Individualization or patient-centered care needs to be a part of the nursing assessment for patients' needs, including patients' preferences (Bak et al., 2012; Bergk et al., 2011; Browne et al., 2011; Chau, 2010). Of note was that some organizational policies and procedures can be a barrier to individualization (Huckshorn, 2004). A case study with a patient who had mental health and intellectual disability issues demonstrated a reduction of restraints when staff assignments were individualized with patient preferences (Jensen et al., 2012). The psychiatric-mental health units' participants indicated careful staffing choices. The concept of staffing choice is consistent with this study when the nurses carefully choose which nurse would work best with certain patients. Kontio et al. (2012) completed a qualitative study with patients looking for their perceptions on to improve restraint practices.

The results showed that the patients' perspectives received insufficient attention and focused on nursing practices that have not been adopted, such as pre-planning and documentation of patient wishes (Kontio et al., 2012). Nurses adapt to the patient's current treatment situation utilizing nursing interventions that focus on the restoration of the mental health of the patient (Holoday Worrett, 2008). The identification of the use of patient space, de-escalation, medications, patient assignments, communication, comfort, and development and support of their WRAP, is specific toward individualization of patient care. The organizational wide adoption of individualization was a not part of this current study but would be a futuristic study to evaluate implementation and follow through of individualize and patient care incorporated into practice. This information allows for further caring moment effect for incorporation.

Evidence: Decision-Making

The decision to use leather restraints was discussed throughout the interviews and all protocol questions. The findings from evidence of decision making include the decision to use leather restraints is major and considered a last resort by the participants, occuring when there is a lack of clinical improvement and a failure of least restrictive measures in the hospital setting. The decision to use restraints is a stressor for nursing staff. This evidence identifies theroretical adaptation opportunities when decision-making occurs.

The initial decision to use a mechanical restraint occurs quickly and in the emergent situation, there is not time for the participant to immediately call the physician to obtain the order, so the nurse makes the decision. The physician is called as soon as the clinical situation is safe. The use of as needed PRN restraint orders are strictly prohibited by the behavioral health governing bodies (CMS, 2013). Once the restraint process begins, the participant nurse assists in the restraint application. The participants mentioned monitoring and assessment of safety,

injury, physical needs, and for readiness for restraint removal. Nurses are the first professional to decide about the application of restraint (Lai, 2007; Larue et al., 2009; Roffe et al., 2007; Ryan & Bowers, 2005). The participants identified that the decision to use restraints was a part of their role.

It was understood from the unit's historical training and more recently that CPI training as the reason for the use of restraint is only if the patient is a harm to themselves or someone else (APNA, 2007b; CMS, 2012; Gelkopf et al., 2009; Lai, 2007; Stewart et al., 2009). The nurse's use of restraint was also considered as a last resort in the literature (Chau, 2010; Lewis et al., 2009). The participants worked diligently to avoid the use of restraints. The decision to use restraint is a complex phenomenon for the psychiatric-mental health nurse and is fraught with ethical dilemmas (Carr, 2012; Goethals et al., 2011; Kontio et al., 2010; Lindsey, 2009). Nurses are simultaneously weighing multiple factors when managing aggressive patients (Lindsey, 2009). The dynamics of the current clinical situation need to be quickly assessed (Lai, 2007). Making the on-the-spot clinical decisions related to restraints is not fully understood (Crook, 2001; Tanner, 2006). The use of restraints is controversial and dangerous and can cause injury to patients and staff, including the chance of death (Barton et al., 2009; Huckshorn, 2004; Lewis et al., 2009; Mohr & Anderson, 2001; Moyo & Robinson, 2012; Terpstra et al., 2001).

The failure of the least restrictive measures does need to be documented as evidence in the patient record supporting the decision to use restraints (Lindsay & Brittan, 2007). The participants noted that documentation was a role that was expected with homicidal and suicidal patients. The least restrictive measures are a requirement of CMS and the Joint Commission (Warren, 2014). The identification of the least restrictive measures identified by the participants were verbal de-escalation, medication, or physical holding, similar to that of the examples from

the literature. The literature examples include therapeutic communication, calming the environment, and administering medications (Leggett & Silvester, 2003; Lewis et al., 2009; Moran et al., 2009; Short et al., 2008).

The use of restraints can lead to distress for the nurse who is trying to maintain the balance between reducing restraints and being therapeutic (Larue et al., 2009). A participant identified the stress of the staff. The staff members wanted to avoid the use of restraint and the supervising nurse had decided to use a restraint, which she believed this was what was best for the patient. The environment surrounding a restraint episode is charged with emotions. Nurses suppress those emotions and can result in frustration, despair, hopelessness, anger, absenteeism, helplessness, substance abuse, retataliation, development of an "I don't care" demeanor, (Bimenyimana et al., 2009, p. 4), guilt, ambivalence (Lai, 2007), uneasiness, anxiety, fear, guilt (Moran et al., 2009; Sequeira & Halstead, 2004), anger, distress, and crying (Sequeira & Halstead, 2004). The participants describe the decision to utilize restraint as difficult.

Evidence: Description of a Time Involved in Leather Restraints

The evidence for this section came primarily from the request: describe a time when a patient was placed in mechanical restraint. As the description of that time each participant was involved in leather restraints was discussed, the findings included the extreme patient behavior and clinical situation led to the leather restraint episode, the patient experience, and staff awareness. Of interest during the initial inquiry phase, two participants had some initial difficulty recalling the last time they had assisted with a restraint process. This may indicate success in restraint reduction because the leather restraint episodes are so infrequent participants had this event in their remote memory. Another thought is that the participant had viewed the

event as a personal trauma. There are opportunities for the theoretical model concept of adaptation within the time a restraint is used within the facility.

A restraint episode can be highly charged as described by the participants in terms of an out of control patient. The participants vividly described patient restraint events in their past, including descriptors such as uncontrollable and violent. The use of restraint is a complex intervention (Hejtmanek, 2010). The description in the literature includes that restraint "is simultaneously a violent" and intimate experience for the patient (Hetjtmanek, 2010, p. 668). The importance of protecting patient dignity was an innate nursing characteristic for the participants. Dignity protection is also the right of the patient (Anonymous, 2001; Dean, 2007; Moylan, 2009). Injuries are typically thought of as physical; the documented literature regarding psychological trauma is plentiful. The participants discussed past traumas of the patients and retraumatization avoidance. In a cross-sectional research study, it was found the use of restraints is an intervention that is contrary to the patient's freedom and autonomy (Kruger et al., 2013). Negative psychological trauma or retraumatization had resulted from the use of restraint (Azeem et al., 2011; Binsfeld, & Jones, 2011; Dahan et al., 2007; Grigg, 2006; Frueh et al., 2005; Huckshorn, 2006; Knight, 2011; Muskett, 2014; McCue et al., 2004; Morrison, 2013; Morrison et al., 2000; Steinert et al., 2007). The patients have reported feelings related to upset, distressed, isolated, and ashamed (Bonner et al., 2002).

The nurse's awareness of his or her role in the nurse-to-patient interactions can positively influence the clinical situation (Bowers et al., 2005; Lane & Harrington, 2011). Views and attitudes of any nurse can create conflict for patient rights (Chien & Lee, 2007). Interpersonal style is a key characteristic that is extremely relevant in the nurse's role with all psychiatric-mental health patients (Dafferen et al., 2010). The participants described

approaching the patient in a respectful manner and that the reduction of restraints has come from a different approach. Pulsford et al. (2013) compared the Management of Aggression and Violence Attitude Scale from patients and staff, the conclusions led to the promotion of interpersonal approaches over the controlling strategies. The Pulsford et al. (2013) study validates the approach used by the participants, talking to the patients in a positive way or offering choices, and the subsequent restraint reduction. Interpersonal relationships are complex and there needs to be an evaluation of the power dynamics within the relationship (Cutliffe & Happell, 2009). Communication was identified as a key characteristic for working with patients.

Evidence: Leather Restraints off the Psychiatric-Mental Health Units

The protocol questions that primarily informed this section were: how has the move of the leather restraints to the off unit utility room made a difference in practice? Participants did not perceive practice change related to the removal of the leather restraints off the psychiatric-mental health units. Literature regarding this specific practice change is lacking. The removal of the restraints is considered an alteration in the psychiatric environment toward the reduction of restraints. The environment or milieu of a psychiatric facility was altered in structure that is focused on safety, such monitoring silverware and cleaning products to avoid self-harm activities to prevent the patients from harming themselves or others (Mills et al., 2010). Leadership as a deterent for use of restraints completed the movement of leather restraints off the units; this environmental change emphasized this purpose. Moosa & Jeenah (2009) write that the use of restraint will become obsolete by advances in psychiatric-mental health care by improvements, such as medications and the therapeutic milieu. The theoretical connection with this evidence is that this is a neutral finding however, identifying this as a caring effect is most logical because

the effect on the nurse-patient relationship considered positive because it reinforced the restraint reduction.

Evidence: Adoption of a Mechanical Restraint-Free Units

The protocol question that primarily informed this evidence section included: if your unit were to adopt the mechanical restraint-free trend, what would be your thoughts and feelings regarding the change and what would it take to go restraint-free? The majority of the participants were not supportive of removing the leather restraints from the building. The concern is that there could be one patient violent enough that safety for all could not be contained. The nurses want to keep the restraints as an option. The participants were not able to determine the best way to make the unit restraint-free. This information influences the theorectical framework as an overall concept.

Carr (2012) in a case study involving one patient found that mechanical restraints can be used with positive outcomes for the patient. Paterson (2005) noted that even with the most rigorous prevention and reduction efforts, restraint might not be entirely excluded as an intervention. Harbison, Allen, & Rogers (2011) discussed the unpredictable nature of elimination of restraints in a mental health setting, as the outcomes are difficult to plan. The elimination of restraints was described as utopian by psychiatric-mental health nurses in the inpatient setting (Muskett, 2014). These articles offer minimal support to a restraint-free practice. In a description of two crisis centers, Ashcroft and Anthony (2008) interpreted the crisis centers' initiative of "elimination rather than reduction of seclusion and restraint is a legitimate goal" to be attained by the crisis centers (p. 1201). The movement toward a recovery model makes the use of restraint incompatible (Ashcraft & Anthony, 2008). Moosa and Jeehah (2009) mention that a restraint-free environment will need to have timely and comprehensive assessments of the

patients with a plan of care developed to identify patient's that are at risk for restraint. The literature reflects the undecided nature for the elimination of restraints.

Theme: Barriers Towards a Restraint-Free Practice.

The barriers that emerged from the participants included current practices, medication, and patient acuity or behaviors. The experience of the clinical professionals and the time constraints for de-escalation relate to the barrier of current practice theme. Medication unpredictability is a barrier. Lastly, the high acuity or patient behaviors as a barrier is discussed below. These barriers are the adaptation opportunities from the theoretical framework previously described.

Current Practice. The findings from the participants included a need for experienced or the right staff working with a patient to assist in a patient crisis event. The team approach could allow for the adjustment in the skill mix of the staff dependent on the patient acuity. Because of the risk of injury to staff and patients it is important to have a multidisciplinary team approach and individualized or person-centered care for the reduction of restraint (Bak et al., 2012; Barton et al., 2009; Goetz & Taylor-Trujillo, 2012; Green, 2010; Linette & Francis, 2011). The team approach is currently available for the psychiatric-mental health units. The time constraint factor away from other nursing duties is not addressed in the literature.

Medication. A decrease of reliance on medication and an increase in therapeutic communication may be essential for the reduction of aggression and violence (Duxbury & Whittington, 2005). In an examination of study with two case studies, there were conflicts and ethical dilemmas surrounding forced medications (Regan, 2010). In both cases, the patients were restrained for a forced medication, and this is where the conflict began with the patient, nurses, and physicians (Regan, 2010). The conflict created a distressed and strained clinical

environment (Regan, 2010). If the clinical situation involves strictly verbal violence, the resolution of the crises without forcing medications was suggested (Bowers, Owiti, Baker, Adams, & Stewart, 2012). Forced medication is permitted at this organization with specific protocols and physician orders. This type of enforcement of medication is helpful in the short-term (Bowers et al., 2012). The focus of the literature for emergency medications supported the use of medications in a critical situation. There was no information in the literature on the speed of the effectiveness toward target symptoms during a psychiatric inpatient crisis.

Patient Acuity or Behavior. High patient acuity and extreme behaviors have been identified as a barrier by the study participants for the removal of restraints out of the building. Unpredictable aggression is often accompanied with hostility and has been problematic and challenging for healthcare providers (Chukwujek & Stanley, 2011; Cookson et al., 2012; Schreiner et al., 2004; Tema et al., 2011). This is consistent with the participants' perceptions as the nurses see violence and unpredictability. Pulsfold et al. (2013) found aggression has a range of causes, including those being internal and external. It is the external factors such as the environment that the psychiatric-mental health nurse (participant) can alter. In a retrospective exploratory study with children, the findings included that patient factors predict aggression and consequently the need for restraint (Crocker, Stargatt, & Denton, 2010). A contributing factor to aggression and violence is the patient's mental status (Bimenyimana et al., 2009). In a multivariate, cross-sectional study of psychiatric-mental health patients there was a strong association with patients who were legally detained and showing aggressive behaviors (Bowers, Van Der Merwe, Paterson, & Stewart, 2012). The factors of aggression, mental status, and legal status are factors that affect the psychiatric-mental health units.

Theme: Facilitators Towards a Restraint-Free Practice.

The philosophy, CPI implementation, practice and culture change, and medication use were identified as the facilitators for the restraint reduction at the psychiatric-mental health units. The philosophy sub themes were trauma informed care, individualization of care, and a supportive administration. Understanding the meaning of the concept of individualized care needs is under question. CPI implementation thought to contribute to the restraint reduction success at the psychiatric-mental health units. The use of medications considered a facilitator as well as previously mentioned barrier. These facilitators are the caring moment effects from the theoretical framework previously described.

Philosophy. The philosophy of trauma informed care is a therapeutic concept that all psychiatric-mental health unit employees at the psychiatric-mental health units are aware. Trauma informed care includes the key concept of patient participation to prevent re-traumatization (Regan, 2010). The patient's involvement in treatment choices can decrease triggering their trauma history and in turn their anxiety and fear. While the use of the concepts of trauma informed care and recovery are common in psychiatric-mental health nursing banter, the translation of these concepts into day–to-day practice is a struggle (Muskett, 2014). The literature supporting the efficacy of restraints is scarce (Carr, 2012). Restraint as an intervention can create re-traumatization for the patient (Muskett, 2014; Regan, 2010). In an integrative review of qualitative studies regarding the perception of patients being physically restrained, Strout (2010) described four themes including retraumatization, negative psychological impact, perceptions of unethical practices, and the broken spirit. The incorporation of trauma-informed care principles within the milieu has been a goal for the psychiatric-mental health units psychiatric-mental health units. The contradiction to trauma-informed care can include the policies and procedures, unit rules, safety rounds, locked doors, mixed-sex population as well

(Muskett, 2014). The development of the nurse-patient relationship and the value of patient-centered care are critical toward a restraint-free practice (Muskett, 2014).

As previously mentioned regarding the risk of injury to staff and patients, it is important to have a multidisciplinary team approach and individualized or person-centered care for the reduction of restraint (Bak et al., 2012; Barton et al., 2009; Goetz & Taylor-Trujillo, 2012; Green, 2010; Linette & Francis, 2011). In a restraint focused systematic review of literature Bak et al. (2012) discovered that the implementation of cognitive therapy in the milieu, a combination of interventions, and individualized care were the interventions that were likely to reduce the use of restraints. The team approach is currently available for the psychiatric-mental health units. Individualization and person-centered care were present in the psychiatric-mental health units in order to avoid the use of restraints (Bak et al., 2012; Browne et al., 2011; Chau, 2010). Person-centered care and individual care concepts are interpreted interchangeably in this dissertation. The use of person-centered care is plentiful in the literature; a qualitative study found that the nurse's understanding for the practice of patient-centeredness needs further definition and adoption into practice by nurses and the multidisciplinary team (O'Donovan, 2007). There was a lack of consistent patient-centered care on a child unit that had implemented child-centered care (Regan, 2006). Goodwin and Happell (2008) found in their literature review that the ideal of person-centered care was not always realized. The policies and procedures of the child unit were the focus of the care delivered to the child, rather than child-centered care (Regan, 2006). A qualitative study was conducted to examine the perceptions of patients and their caregivers regarding barriers to forming a collaborative relationship (Goodwin & Happell, 2008). In a quantitative study regarding patients' perceptions of restraints, the findings included that patients' opinions were not taken into consideration (Soininen et al., 2013). As part of

implementing individualized care the practice culture changes need to include the patient's involvement in treatment planning (Soininen et al., 2013). The staff attitude of respect and encouragement promotes person-centered care (Goodwin & Happell, 2008).

Curran (2007) indicates that there is a strong stance with administrators, professional organization, and governing bodies toward the reduction of restraint. Leadership support is required for the elimination of restraints (Allen, De Nesnera, & Souther, 2009). A clear leadership style and a transparent plan that ties to the mission and philosophy of the organization will contribute to the reduction of restraints (Huckshorn, 2004). The cost of a single restraint event was estimated to cost up to $354.51 as well as hidden costs related to staff turn-over and an increase in job satisfaction (Morrison, 2013). The APNA (2007a), in the restraint position statement, indicated that the nursing leadership has the responsibility for the welfare and safety of the psychiatric patient and staff. Administration has an influence on the usage of restraint (APNA, 2007a; Chau, 2010; Ferlegen & Morrison, 2013; Ryan, 2009). The leadership at the psychiatric-mental health units supported the restraint reduction through staff education and review of restraint events.

CPI Implementation. The participant's comments indicated success of the CPI program at this facililty. CPI and Collaborative Problem Solving are education programs that have demonstrated success in the reduction of restraints (CPI, 2012; Johnson, 2010; Martin et al., 2008; Smith et al., 2003). CPI use was identified as a turning point for a restraint-free environment by Chau (2010). Warren (2014) wrote about the implementation of the CMS regulations regarding force against patients. The use of a de-escalation education program with certification (CPI was specifically mentioned) is invaluable when dealing with charged emotional situations (Warren, 2014). It is with a shared vision regarding restraint reduction,

including shared beliefs and behaviors, that the use of restraints can be further reduced (Huckshorn, 2012). The staff gained a shared vision through the adoption and implemention of CPI at the psychiatric-mental health units in October of 2012.

Practice and Culture Change. Staff members need to be able to evaluate their verbal and non-verbal communication to understand their effect on the patients, according to CPI this is the integrated experience (CPI, 2012). It is the change in the clinical environment that offers a reduction of restraint (Sullivan et al., 2005). When staff are more aware of their behaviors, this contributes to the reduction of restraint (Fralick, 2007). Management sets the practice tone of a facility, including setting restraint use parameters, and changing negative role perceptions and attitudes (Ferlegen & Morrison, 2013; Paterson et al., 2011; Pollard et al., 2007; Sivakumaran et al., 2011). The leadership at the psychiatric-mental units offered this necessary support and encouragement. The empowerment of nurses to identify escalation early comes from the CPI curriculum (CPI, 2012). Empowerment, education, a consistent infrastructure, resources, ongoing information, and opportunities for support, feedback, and growth assist in the positive growth of a practice change (Chandler, 2012; Kontio et al., 2009; Tema et al., 2011).

It is through the early identification of escalating behaviors that care can be individualized to avoid more restrictive safety measures such as seclusion, physical hold, or restraint (D'Orio, Pureselle, Stevens, & Garlow, 2004; Goetz & Taylor-Trujillo, 2012; Irwin, 2006). The participants continually indicated the importance of early identification of patient changes as a part of their nursing safety role. This was transferred from nursing knowledge to the patients. The patients worked with nursing staff to identify triggers, early warning signs, and coping skills. Through nurse's awareness to identify the patient behaviors early, the nurse also needs to understand factors that may increase bias toward the patient (DeBenedictus et al., 2011;

Marangos-Frost & Wells, 2000). The nurse's awareness of his or her role or behavior in the nurse-to-patient interactions can positivily influence the clinical situation (Bowers et al., 2005; Lane & Harrington, 2011). Conversely, the view and attitudes of a nurse can create conflict for patient rights (Chien & Lee, 2007). Interpersonal style is a key characteristic that is extremely relevant in the nurse's role with all psychiatric-mental health patients (Dafferen et al., 2010). Interpersonal relationships are complex and there needs to be an evaluation of the power dynamics within the relationship (Cutliffe & Happell, 2009). Nurses represent a hierarchical power over a consumer and in order to equalize that power consumers need to be empowered to be a part of their care (Cutliffe & Happell, 2009). Some of the skills for psychiatric-mental health nurses are being present and becoming aware, caring and connecting, balancing, and deciding how to respond (Delaney & Johnson, 2006). Nurses can gain sound clinical judgment by identifying patterns, responses, and the positive engagement of psychiatric-mental health patients (Tanner, 2006). Gaining an understanding of why restraint happens can lead to a reduction in the use of restraints (Paterson, Wilkinson, McComish, & Smith, 2013). The significance of the early identification of patient behaviors is also a part of the nursing role described by the participants. The awareness of the nursing staff regarding bias and influence in the patient interactions should be studied.

Medication. The participants have indicated psychotropic medication as a facilitator toward restraint-reduction. Psychotropic medications were introduced in the 1950s, prior to other biologic treatments including restraint (Knight, 2011; Shives, 2008). Medications have been found successful in aggression and symptom reduction in the short-term (Bowers et al., 2012). The participants used medications for very symptomatic patients. Medications to calm the patient can be used as a management of aggression and violence (Bowers et al., 2012). If

medications are used for rapid tranquillizing there needs to be monitoring for adverse outcomes, such as cardiac complications, neuroleptic malignant syndrome dystonia, decreased respiratory rate, irregular or slower pulse, drop or decrease in blood pressure, and others associated with the specific medications (Dickinson, Ramsdale, & Speight, 2009). The participants indicated that medications were a faciliator to avoiding the use of restraints.

Quality Criteria

The construct validity testing was met for this study. The researcher included multiple sources of evidence to maintain objectivity. The sources of evidence included documentation from the psychiatric-mental health units, the participants' review of transcripts, and peer debriefing. The reports were objective documents that would be available at other psychiatric-mental health facilities. The participant transcripts reviewed multiple times by the researcher and by the participant. The peer-debriefer met with the researcher and confirmed the identified emergent themes. The correct operational measures were identified and objectivity was met.

External validity testing was met for this study. The findings from this study were logical and transferable to settings similar to the psychiatric-mental health units or analytic generalization. Analytic generalization followed Yin's (2011) stepwise process that the findings from this study can inform a particular set of concepts; in this case, it was the concepts detailed within the dissertation toward a restraint-free practice. The second step was that the findings can be implicated to other psychiatric-mental health nursing settings. The detail of the study design, method, and conclusions written in rich detail so that the findings could be applied as evidence in other psychiatric-mental health units. Credibility was also included within the external validity realm to determine the believability. The researcher employed member-checking with the participants. The participants reviewed and validated the transcripts for accuracy of content.

Reliability testing was met for this study. As discussed previously, the detail of the study design, method, and conclusions written in such rich detail the study findings can be replicated as well as applied to other psychiatric facilities. The inclusion and exclusion criteria were detailed and confirmed with the demographic form. Through a peer-debriefing process, the final themes were validated. The peer-debriefer was a committee member for this study with qualitative expertise. An independent analysis of two interviews by the peer-debriefer was completed. The researcher and the peer-debriefer compared operational definitions and the coding process. The peer-debriefer and the researcher confirmed the final study themes.

Assumptions

The assumptions for this study included that all of the participants have mechanical restraints available as an intervention and that the nurses will be able to articulate their perceptions of a mechanical restraints process. This was confirmed during the interviews, all of the participants knew there were restraints in the building and each participant was able to articulate the process. This was also confirmed through the interview data and analysis. These assumptions were valid for this qualitative exploratory case study.

Delimitations

The self-imposed limit for the scope of this study was identified as limiting this study to the psychiatric-mental health nurses. The psychiatric-mental health units' staff works as a team. The team members include recovery specialists, therapists, support staff, recreational therapists, and the Chaplain. An additional study with the other team member's perspectives could add more depth to a study such as this.

Limitations

The limitations are the potential weaknesses within this study. These were identified in chapter 3. The first identified limitation included that the leadership or administration was supportive of a restraint-free practice. This limitation did not turn out to be an issue for the participants, as the restraint-free practice has become part of their nursing culture; there was no apparent affect on the participant's behaviors, beliefs, or practices. The leadership support could have affected their responses, creating a bias. The second and third limitations were identified as the case study design, where generalizability or transferability would be limited to units with the same description as the two psychiatric-mental health units that was the case for this study, and the subjectiveness of case study methods. Both were true for this study. The limitations for this study are inherent in a qualitative design. This includes the smaller sample size and the volume of data. The fourth limitation included self-disclosed information, which is the nature of qualitative studies. The unique information from the participants was told to the researcher in a rich and believable manner. The last two limitations were related to the researcher being an employee of the psychiatric-mental health units and colleague of the participants. Neither of these limitations was problematic during this study. The researcher kept a journal and did not identify any bias or social interactions that were limitations for this study.

Recommendations

The recommendations from this study include further inquiry into the answers from the nurse's role in a psychiatric facility, specifically looking at the perceptions of the nurse's acceptance of their working environment. Another recommendation would be to study the nurse's awareness of his or her own interactions, interpersonal style, bias, and attitudes towards psychiatric-mental health patients who are aggressive. Psychiatric-mental health nurses are integral to patient incident management and understanding this role is critical to the reduction of

restraints. The third recommendation relates to the nurse's role to define the incorporation of individualized care in psychiatric mental health units. The concept of individualized care was identified throughout the interviews. The literature indicates that individualized care is not always realized in the spirit of the concept, throughout organizations.

The decision-making theme included that the decision to use restraints is a major one. Two areas of inquiry evolved from the process of coding and include: what are the specifics of that major decision and what are the underlying motivations regarding the participants' passion to avoid the use of restraints? The specific steps in making the decision to use restraints was not the scope of this study. Of interest was the use of least restrictive measures prior to the use of restraints. Further exploration of using these least restrictive measures may reveal further movements toward a restraint-free practice. The participants strongly indicated restraints were used as a last resort. Further enlightenment about the movement towards a restraint-free practice could be revealed.

The answers regarding the question of the nurses describing a time when they used restraints found two of the twelve participants could not readily recall the details of such event. The topic that needs further study is the reason for the lack of initial recall. This is a phenomenon that was not understood by this researcher. A concept analysis surrounding the recall of leather restraint episodes might assist with understanding the recall phenomenon or how nurses as well as patients can be traumatized. By completing a qualitative study, understanding the trauma of the nurse regarding nurse restraint trauma would provide impressive insight on this topic.

Physical removal of the leather restraints from the units was not perceived as a practice change. There was no information in the literature about this type of removal from psychiatric facilities. The exploration of this type of environmental alteration needs further research to

discover the impact of decreasing access to leather restraints (such as removing leather restraints off of the units) at other psychiatric-mental health inpatient facilities. It is recommended that the intervention of moving the restraints to an off unit location be tested at another similar psychiatric facility.

The participants did not generally support the adoption of a mechanical restraint-free unit. They were not able to identify what it would take to become a restraint-free unit. The best practices towards becoming a restraint-free practice include the patient assessment and plan previously discussed as well as staff education and the view that restraints are extraordinary, while maintaining the dignity of the patient (Moosa & Jeenah, 2009). Additional studies focusing on this topic would increase the understanding of the details related to a unit becoming restraint-free in the future.

With the theme of barrier for restraint removal: current practice, what is not known is what staff meant by the expression of experience level of the staff. The experience of staff at one facility was related to persons who were leaving to different positions outside of the acute care units (McGeorge & Rae, 2007). This needs further exploration at the psychiatric-mental health units; the recommendation would be to evaluate what is meant by experience and how a team might close the gap perceived by the participants. As for the medication barrier, the unpredictability and effectiveness of medications in a crisis needs more inquiry, especially regarding the speed of effectiveness toward target symptoms in a crisis event with a patient. The use of medication was discussed in the literature; however, the helplessness of the nursing staff related to the unpredictability and effectiveness of medications was not. A qualitative study documenting the experiences of nurses with patients with differing diagnosis may begin to answer this topic.

The barrier theme of patient acuity or behavior was well documented in the literature. It would be important to examine the difference of the patients' presenting symptoms currently to those of the past to determine the type of patients that are being admitted to the psychiatric-mental health units and the effects on restraint use. This picture would provide another snapshot of the restraint reduction progress at this facility.

Regarding the theme of facilitators for restraint removal recommendation more needs to be known about the implementation of individualized care. The participants discussed implementation of patient centered care; however, in the literature, there was discussion regarding full implementation within an organization is rare. A study investigating the depth of individualized care implementation within organization would create patient centered care evidence for nursing.

Another area of interest is the idea that medication use is both a barrier and a facilitator. A study focused on understanding this phenomenon would greatly add to psychiatric-mental health nursing science. The study could include two different psychiatric-mental health facilities. A questionnaire with open-ended comments could be used to gather perceptions of medication use in psychiatric-mental health facilities.

The facilitator of supportive leadership was an important factor for this case study site. The leadership set the expectation that restraints would be reduced. There was a visible show of support and oversight. A recommendation is to delve into the perceptions of leadership on how the reduction occurred.

The implementation of CPI was reported to be a success at this facility. The literature shows similar success. The early identification of escalating behaviors was important at the psychiatric-mental health units, as there was staff intervention early to prevent further escalation.

Many facets contributed to this practice and culture change. The recommendation for these facilitator themes is to re-examine this facility in a longitudinal study using a similar qualitative study. Such data can offer a wealth of information regarding practice and culture change and persistence, as well as the perceptions of the leadership and their view on how the practice and culture changed, towards successful restraint reduction.

Other recommendations are to repeat this study on other inpatient psychiatric-mental health units. Because, this study focused on one portion of the inpatient team, the nurses are only one facet of the patient's treatment team. This study needs to be repeated including the various other inter-disciplinary treatment teams, as this would offer another view of the restraint reduction from a team approach.

Third Party Data Use

An editing service was utilized. The service was only used for grammatical and American Psychological Association formatting (Appendix M). No other third party was utilized.

Summary

This study documented the perception of psychiatric-mental health nurses toward a restraint-free practice. The use of a qualitative exploratory study has allowed for free flowing ideas from the nurses toward documenting their current practice and their perceptions from the past, present and projecting into the future. As the protocol questions from the interview were discussed in context with the findings from chapter 4, the understanding of the responses from the participants created rich detail for the recommendations. This is a newer area of study and other studies have emerged as recommendations.

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Appendix A

For: GOETZ,SUZANNE From: SUZANNE GOETZ
Tue Apr 29, 2014 5:09 pm Taken by: SUZANNE GOETZ (627-2292)
Subject: Research Study-Perceptions Toward a Restraint-Free Practice:

Perceptions Toward a Restraint-Free Practice: A Case Study

University of Phoenix
Good Samaritan Health Systems

Suzanne Goetz
Kearney, Ne 68845
sggoetz@charter.net
308-627-2292

All Nurses,

I am writing to invite you to participate in a research study to complete my dissertation. I am a PhD Nursing student at the University of Phoenix. My focus for this study is the psychiatric nurse and their perception of their unit going to a restraint-free environment.

My plan is to have a conversation with you to get your opinion and experiences related to your patient population.

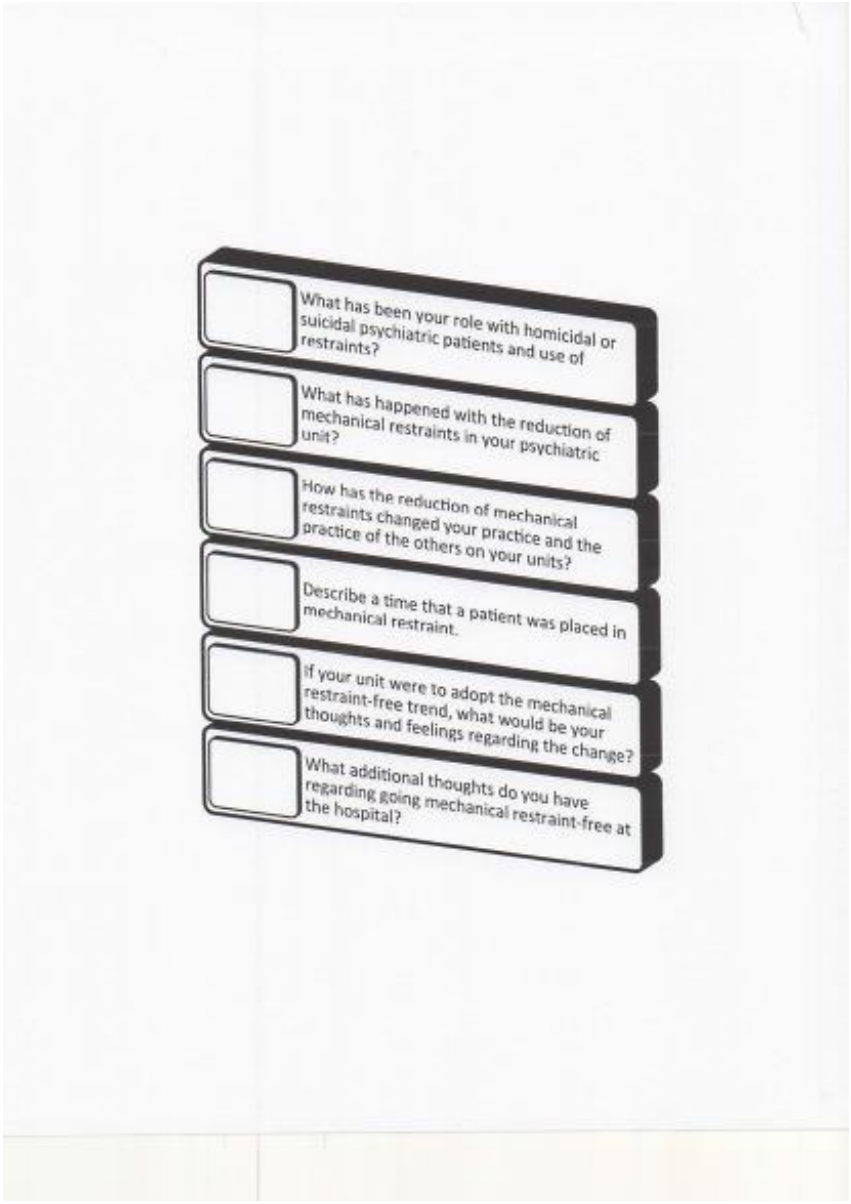
Please contact me if you are interested in participating. I will follow up with a telephone call to discuss your interest in participating.

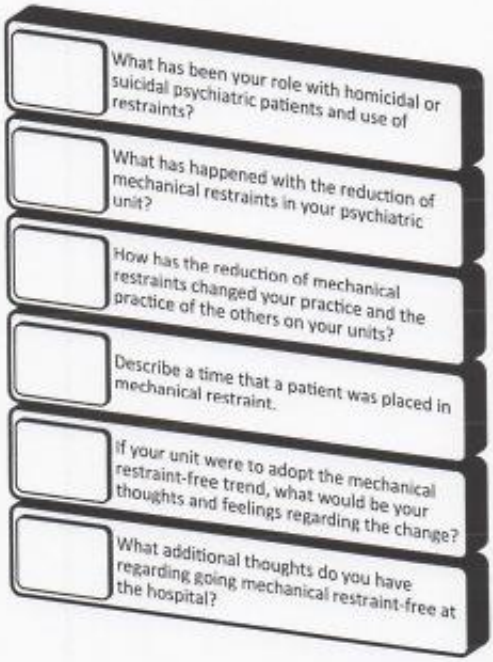
Sincerely,
Suzanne Goetz, PhD Candidate, MSN, CCS-P

SENT TO: #RYH.NURSES, SUZANNE GOETZ

Appendix B

Interview Protocol and Revision




What has been your role with homicidal or suicidal psychiatric patients and use of restraints?
What has happened with the reduction of mechanical restraints in your psychiatric unit?
How has the reduction of mechanical restraints changed your practice and the practice of the others on your units?
Describe a time that a patient was placed in mechanical restraint.
If your unit were to adopt the mechanical restraint-free trend, what would be your thoughts and feelings regarding the change?
What additional thoughts do you have regarding going mechanical restraint-free at the hospital?

Appendix C

Demographic Form

Perceptions Toward a "Restraint-Free' Practice

Demographic Information
by Suzanne Goetz

Please mark the correct answer for the following demographic information:

Is your employment: ____ Full Time ____ Part Time (less than 35 hours)

Is your employment: ____ Permanent (regular hospital employee) ____ Other
____ Temporary (Agency

Age: ____ 20-29 ____ 30-39 ____ 40-49 ____ 50-59 ____ 60+

Licensure ____ LPN ____ RN

Highest Education Level ____ Diploma ____ Bachelor in Nursing

____ Assoc. Degree ____ Doctorate

____ Bachelor in another field ____ Masters in another field

____ Masters in Nursing

How many years have you worked as a nurse? ____ Less than 1 year Number of Years ____

How many years have you worked as a Psychiatric-Mental Health Nurse? ____ Less than 1 year Number of Years ____

As a Psychiatric-Mental nurse at this hospital? ____ Less than 1 year Number of Years ____

Appendix D

Interview Confirmation and Validation Form

Transcript Confirmation and Validation

I have had the opportunity to read the transcription of my interview with Suzanne Goetz.

The transcript is an accurate reflection of our taped interview conversation regarding the Perceptions Toward a Restraint-Free Practice: A Case Study.

_____
Participant

_____
Researcher

Appendix E

Permission Taylor-Trujillo

UNIVERSITY OF PHOENIX

LETTER OF COLLABORATION AMONG INSTITUTIONS

Date: **05/01/2013**

To: Office of the Provost/Institutional Review Board
University of Phoenix

This letter acknowledges that

Good Samaritan Hospital-Richard Young Hospital is collaborating with Ms. Suzanne Goetz enrolled in the PhD in Nursing program at the University of Phoenix in conducting the proposed research. We understand the purpose of this research is to improve the understanding of the Restraint-Free Trend from the Nurses at your facility. And will be conducted under the supervision of Dr. Francine Nelson

This project will be an integral part of our institution/agency and will be conducted as a collaborative effort and will be part of our curriculum/research/data/service delivery model.

Sincerely,

Representative
Collaborating Institution/Agency

1

Appendix F

Permission Hansen

UNIVERSITY OF PHOENIX

LETTER OF COLLABORATION AMONG INSTITUTIONS

Date: 11/30/2013

To: Office of the Provost/Institutional Review Board
University of Phoenix

This letter acknowledges that Good Samaritan and Richard Young Hospital

is collaborating with Suzanne Goetz
(Name of the agency)

Ms. Goetz is enrolled in the Doctorate Degree of Nursing at the University of Phoenix

in conducting the proposed research. We understand the purpose of this research

is Perceptions toward a 'Restraint-Free' Hospital: A Case Study

and will be conducted under the supervision of Dr. Francine Nelson.

This project will be an integral part of our institution/agency and will be conducted as a collaborative effort and will be part of our curriculum/research/data/service delivery model.

Sincerely,

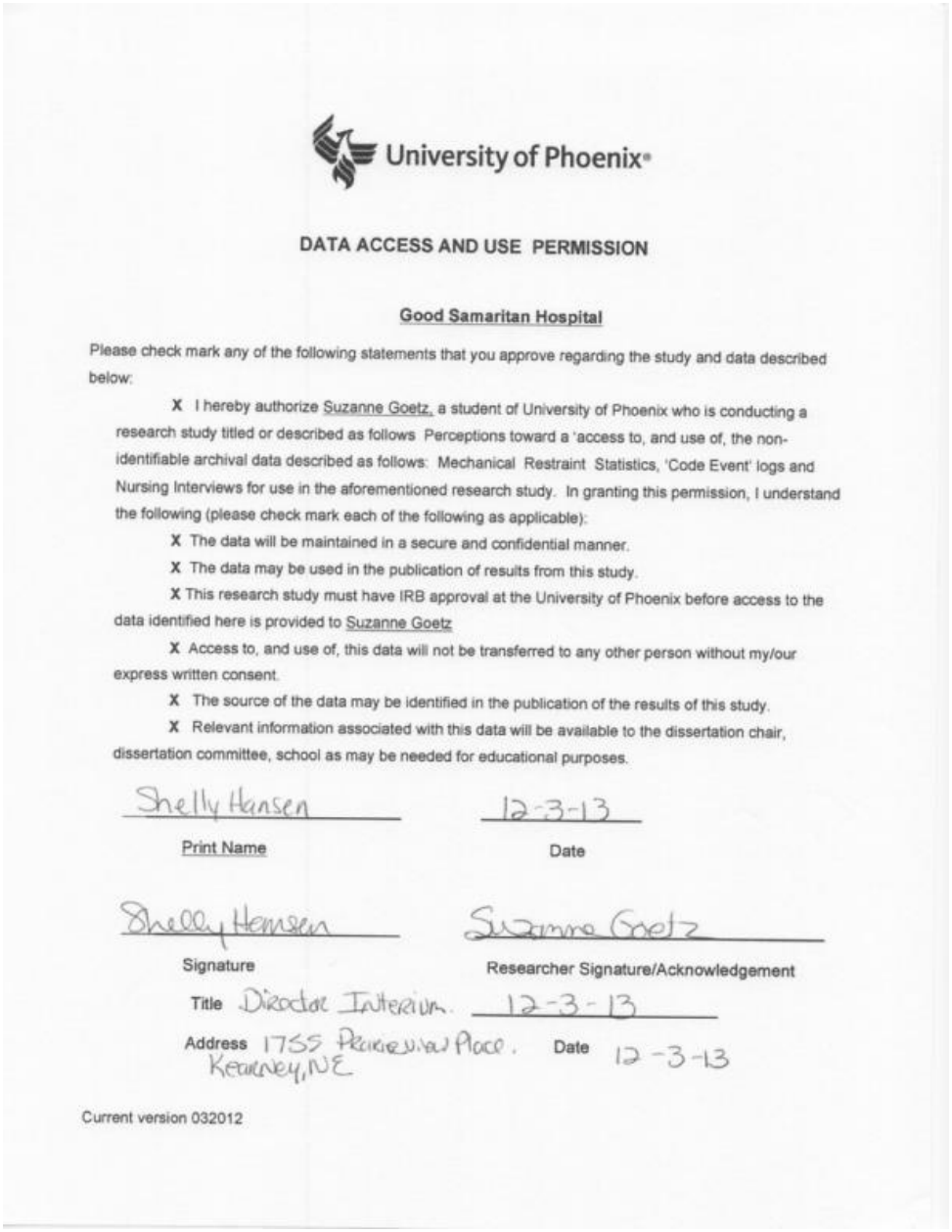
Shelly Hansen

Representative
Collaborating Institution/Agency

1

Appendix G

Data Use and Access Permission



University of Phoenix®

DATA ACCESS AND USE PERMISSION

Good Samaritan Hospital

Please check mark any of the following statements that you approve regarding the study and data described below:

X I hereby authorize Suzanne Goetz, a student of University of Phoenix who is conducting a research study titled or described as follows Perceptions toward a 'access to, and use of, the non-identifiable archival data described as follows: Mechanical Restraint Statistics, 'Code Event' logs and Nursing Interviews for use in the aforementioned research study. In granting this permission, I understand the following (please check mark each of the following as applicable):

X The data will be maintained in a secure and confidential manner.

X The data may be used in the publication of results from this study.

X This research study must have IRB approval at the University of Phoenix before access to the data identified here is provided to Suzanne Goetz

X Access to, and use of, this data will not be transferred to any other person without my/our express written consent.

X The source of the data may be identified in the publication of the results of this study.

X Relevant information associated with this data will be available to the dissertation chair, dissertation committee, school as may be needed for educational purposes.

Shelly Hansen — 12-3-13

Print Name — Date

Shelly Hansen — Suzanne Goetz

Signature — Researcher Signature/Acknowledgement

Title Director Interim. 12-3-13

Address 1755 Prairieview Place. Date 12-3-13
Kearney, NE

Current version 032012

Appendix H

Institutional Review Board Approvals

CATHOLIC HEALTH INITIATIVES®

Good Samaritan Hospital

NOTICE OF IRB APPROVAL Page 1 of 2

GOOD SAMARITAN HOSPITAL
ATTN: IRB
10 E. 31ST ST., P.O. BOX 1990
KEARNEY, NE 68848
308-865-7882

To: Suzanne Goetz
Richard Young Hospital
Kearney, NE 68847

Re: IRB #0214-01
Protocol Version: 02/06/14
Perceptions Toward a Restraint-Free Practice: A Case Study

Date March 7, 2014

This is to inform you that the IRB at Good Samaritan Health Systems has approved the above research study.

The approval period is from **02/26/2014 to 02/26/2015. Your study number is 0214-01. Please be sure to reference this number in any correspondence with the IRB.**

Continued approval is conditional upon your compliance with the following requirements:

- A **stamped** copy of the **Informed Consent Document**, approved as of **02/26/2014**, is enclosed. No other consent form should be used. It must be signed by each subject prior to initiation of any protocol procedures. In addition, each subject must be given a copy of the signed consent form.
- All protocol amendments and changes to approved research must be submitted to the IRB and not be implemented until approved by the IRB except where necessary to eliminate apparent immediate hazards to the study subjects.
- Advertisements, letters, internet postings and any other media for subject recruitment must be submitted to IRB and approved prior to use.
- Significant changes to the study site and significant deviations from the research protocol must be reported.

A spirit of innovation, a legacy of care.

10 E 31st Street P.O.Box 1990 Kearney,NE 68848-1990 Phone 308.865.7100

NOTICE OF IRB APPROVAL

- Enclosed is an Adverse Event Report. All deaths, life-threatening problems or serious or unexpected adverse events, *whether related to the study article or not*, must be reported to the IRB.

- Please complete and submit reports to the IRB as follows:

  Renewal of the study - complete and return the Continuing Review Report-Renewal Request 4 weeks prior to the expiration of the approval period. The study cannot continue after **02/26/2015** until re-approved by the IRB.

  Completion, termination, or if not renewing the project - send the report upon completion of the study.

Please call me if you have any questions about the terms of this approval.

Sandra Rosse
IRB Administrator

Copy: File

Enclosures: Informed Consent Document
Serious Adverse Event Report Form

Good Samaritan Health Systems
IRB Approved: 2/26/14
Expires: 2/26/15

Subject: 4-28-2014 IRB Results: Initial Approval - Suzanne Goetz

Dear Suzanne Goetz:

We are pleased to inform you that your IRB Application was reviewed with a preliminary decision of "Initial Approval" and your study was determined to be exempt. While this decision is subject to full Board confirmation at their next scheduled meeting, you may begin data collection at this time based upon the preliminary decision. Upon confirmation of this decision by the full Board, a communication documenting the decision will be sent to you for your records. In the interim, if you need further verification of this decision or have any questions, please contact IRBChairSubmissions@phoenix.edu. The following also applies to your current Application: 1. If the full Board has any questions or wants clarification about any aspects of your study, or if the Board confirms any potential IRB-related problem areas that were not previously identified, you and your dissertation chair will be notified and the Board's specific guidance will be provided. In this case, you may be asked to provide additional information, respond to questions, or revise some aspect of your study to address Board concerns or questions. You will be expected to resubmit your revised application and any other appropriate information for Board follow up**. Although such actions by the Board are not common, we want you to understand that this outcome is possible and, in case it does occur, data collection should be suspended until the Board notifies you that data collection may resume.**

2. If any significant changes to the approved study are made in the future such as, but not limited to, a change of venue for any data collection sites, change of subject group, data collection methods, etc., resubmission to the IRB for approval of these changes is required. **In this case, data collection should be suspended until there is an IRB decision reported to you.** To initiate review of a change to your study, please complete a "**IRB Change Request for Previously Approved Study**" form which can be found on the SAS Web and submit the completed form along with an updated copy of your IRB Application with appended documentation to: IRBChairSubmissions@phoenix.edu.

Please note that any preliminary decision on this change must also be confirmed by the Full Board.

3. You are now eligible to attend any of the following workshops listed below. If you are interested, and would like to learn more, please contact your Academic Counselor for further information.

- **Dissertation Data Analysis, Presentation, and Interpretation**
- **Dissertation Conclusions and Recommendations**
- **Dissertation Oral Defense**
- **Qualitative Data Coding for Phenomenological Studies** (We wish you the best of luck in successfully completing your dissertation.
- Sincerely, Dissertation Services (**Diane Gavin, PhD**

Doctoral Campus College Chair for Research, School for Advanced Studies

University of Phoenix

Date: Tue, 17 Jun 2014 12:26:33 -0700
Subject: 6-17-14 IRB: Full Board Review: Approved - Suzanne Goetz

Date 6-17-2014

Dear **Suzanne Goetz**:

The role of the University of Phoenix Institutional Review Board (IRB) is to review research studies proposed by students, faculty and others to determine compliance with federally mandated regulations and local requirements regarding protection of human subjects in research studies conducted in accordance with University policies. Your IRB Application for the research study titled *Perceptions Toward a Restraint-Free Practice: A Case Study* was recently reviewed by the Board. I am pleased to confirm that the Board has determined your IRB Application is approved and your study is determined to be exempt. This means you may proceed/continue with data collection.

Please understand that this approval is subject to the following:

1. The approval is valid for one year from the date of this communication. If your research study is not completed by one year from the date of this communication, the approval will expire and you must resubmit a completed "Request for IRB Time Extension" form and an updated copy of your IRB Application. For further information regarding this process, please reference the IRB Advisement Tool. All advisement tools can be found on the SAS Web within eCampus.

2. IRB approval for your research study is based upon the information you provided in your IRB Application. If any aspects of your research study change significantly (such as a change in scope, data collection sites, etc.), you must notify the Board of the changes and request approval for continuance of the research under the new conditions. This can be done through the "IRB Change Request for Previously Approved Study" form. Please consult with your Dissertation Chair if you have a question as to whether a change you have made requires Board review and approval.

3. Any conditions that may be associated with this approval decision must be satisfied before data collection commences. Notification of fulfillment of conditions to the Board is required and Board concurrence is expected. Notification may be done by contacting the Board at: IRB@phoenix.edu.

4. Please retain this communication as documentation of IRB approval of your study.

5. Any conflict of interest that may occur with regard to your study or your role as the primary researcher must be reported promptly to the IRB.

6. Permission to use published surveys, materials, private databases, or other records must have the explicit approval of the author/owner.

7. Any tape recording associated with data collection must be explicitly stated as part of the Informed Consent to which subjects must agree.

8. Individual identity protection must be maintained and separation of Informed Consent from the primary data collection instrument is required.

If you have any questions about human subject protection in research, please refer to the CITI web site (www.citiprogram.org) or contact the University of Phoenix IRB at IRB@phoenix.edu. Best wishes for the successful completion of your study.

Sincerely,

Institutional Review Board

Rick Fizz
Faculty Liaison - Academic Affairs

University of Phoenix
School of Advanced Studies

Appendix I

Confidentiality Statement

University of Phoenix®

Perceptions toward a 'Restraint-Free' Hospital: A Case Study
Suzanne Goetz

CONFIDENTIALITY STATEMENT

As a researcher working on the above research study at the University of Phoenix, I understand that I must maintain the confidentiality of all information concerning all research participants as required by law. Only the University of Phoenix Institutional Review Board may have access to this information. "Confidential Information" of participants includes but is not limited to: names, characteristics, or other identifying information, questionnaire scores, ratings, incidental comments, other information accrued either directly or indirectly through contact with any participant, and/or any other information that by its nature would be considered confidential. In order to maintain the confidentiality of the information, I hereby agree to refrain from discussing or disclosing any Confidential Information regarding research participants, to any individual who is not part of the above research study or in need of the information for the expressed purposes on the research program. This includes having a conversation regarding the research project or its participants in a place where such a discussion might be overheard; or discussing any Confidential Information in a way that would allow an unauthorized person to associate (either correctly or incorrectly) an identity with such information. I further agree to store research records whether paper, electronic or otherwise in a secure locked location under my direct control or with appropriate safe guards. I hereby further agree that if I have to use the services of a third party to assist in the research study, who will potentially have access to any Confidential Information of participants, that I will enter into an agreement with said third party prior to using any of the services, which shall provide at a minimum the confidential obligations set forth herein. I agree that I will immediately report any known or suspected breach of this confidentiality statement regarding the above research project to the University of Phoenix, Institutional Review Board.

Signature of Researcher	Printed Name	Date
Suzanne Goetz	Suzanne Goetz	12-3-13
Signature of Witness	Printed Name	Date
Shelly Hansen	Shelly Hansen	12-03-13

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Appendix J

CITI Training Certificate

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI)

HUMAN RESEARCH CURRICULUM COMPLETION REPORT

Printed on 10/09/2013

LEARNER	Suzanne Goetz (ID: 2068602) 2107 W 35th St Kearney Ne 68845
DEPARTMENT	Nursing
PHONE	308-627-2292
EMAIL	sggoetz1@email.phoenix.edu
INSTITUTION	University of Phoenix
EXPIRATION DATE	10/09/2015

GROUP 1.SOCIAL / BEHAVIORAL RESEARCH INVESTIGATOR AND KEY PERSONNEL. : Complete all required modules. Complete optional modules if they pertain to your research activities.

COURSE/STAGE:	Refresher Course/2
PASSED ON:	10/09/2013
REFERENCE ID:	10673645

REQUIRED MODULES	DATE COMPLETED	SCORE
SBE Refresher 1 – Instructions	10/09/13	No Quiz
SBE Refresher 1 – History and Ethical Principles	10/09/13	2/2 (100%)
SBE Refresher 1 – Federal Regulations for Protecting Research Subjects	10/09/13	2/2 (100%)
SBE Refresher 1 – Defining Research with Human Subjects	10/09/13	2/2 (100%)
SBE Refresher 1 – Informed Consent	10/09/13	2/2 (100%)
SBE Refresher 1 – Privacy and Confidentiality	10/09/13	2/2 (100%)
SBE Refresher 1 – Assessing Risk	10/09/13	2/2 (100%)
SBE Refresher 1 – Research with Children	10/09/13	2/2 (100%)
SBE Refresher 1 – Research in Educational Settings	10/09/13	2/2 (100%)
SBE Refresher 1 – Research with Prisoners	10/09/13	2/2 (100%)
SBE Refresher 1 – International Research	10/09/13	1/2 (50%)

For this Completion Report to be valid, the learner listed above must be affiliated with a CITI Program participating institution or be a paid Independent Learner. Falsified information and unauthorized use of the CITI Progam course site is unethical, and may be considered research misconduct by your institution.

Paul Braunschweiger Ph.D.
Professor, University of Miami
Director Office of Research Education
CITI Program Course Coordinator

Appendix K

Informed Consent

Good Samaritan Health Systems
Kearney, Nebraska

University of Phoenix®

INFORMED CONSENT: PARTICIPANTS 18 YEARS OF AGE AND OLDER

Dear Nurse Participant,

My name is Suzanne Barnum Goetz and I am a student at the University of Phoenix working towards a PhD in nursing degree. I am doing a research study entitled Perceptions Toward a Restraint-Free Practice: A Case Study. The purpose of the research study is to identify facilitators and blockers for the removal of mechanical restraints from the psychiatric units.

Your participation will involve signing an informed consent, filling out a demographic sheet, participating in a recorded interview conversation, and written confirmation of the interview transcript. This will take approximately 90 minutes of your time. You can decide to be part of the study or not without any penalty or loss of benefits. If you would like to withdraw from the study, you will need to notify me in writing with the date and time noted within 24 hours. The results of the research study will be published but your identity will remain confidential and your name will not be made known to any outside party.

In this research, there are no foreseeable risks to you except in the case of the loss of confidentiality. I will be the only person that will have access to your name and your approval of the transcript. I will use unique identifiers on your demographic and transcript. After the data analysis is completed, I will store this information and the recorded interviews within an electronically locked file.

Although there may be no direct benefit to you, a possible benefit from your being part of this study is your involvement in advancing the knowledge of psychiatric-mental health nursing.

If you have any questions about the research study, please call me at 308-627-2292 (text or call) or sggoetz@charter.net. For questions about your rights as a study participant, or any concerns or complaints, please contact the University of Phoenix Institutional Review Board by email at IRB@phoenix.edu and/or the Good Samaritan Hospital Institutional Review Board - Sandy Rosse at 308-865-7882

As a participant in this study, you should understand the following:

1. You may decide not to be part of this study or you may want to withdraw from the study within 24 hours. If you want to withdraw, you can do so without any problems.
2. Your identity will be kept confidential.
3. Suzanne Goetz, the researcher, has fully explained the nature of the research study and has answered all of your questions and concerns.
4. The interviews will be recorded. You are giving permission for the researcher, Suzanne Goetz, to record the interviews. You understand that the information from the recorded interviews will be transcribed. The researcher will develop a way to code the data to assure that your name is protected.
5. Data will be kept in a secure and locked area. The data will be kept for three years, and then destroyed.
6. The results of this study will be published.

"By signing this form, you agree that you understand the nature of the study, the possible risks to you as a participant, and how your identity will be kept confidential. When you sign this form, this means that you are 18 years old or older and that you give your permission to volunteer as a participant in the study that is described here."

(☐) I accept the above terms. (☐) I do not accept the above terms. (CHECK ONE)

Signature of the interviewee _____ Date _____

Signature of the researcher _____ Date _____

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Good Samaritan Health Systems
IRB Approved: 2/26/14
Expires: 2/26/15

Appendix L

Introduction Letter

Perceptions Toward a Restraint-Free Practice

University of Phoenix®

Good Samaritan Health Systems
Kearney, Nebraska

Suzanne Goetz
Kearney, Ne 68845
sggoetz@charter.net
308-627-2292 for call or text

All Nurses:

Thank you for agreeing to this interview today. As you will see, I have enclosed an informed consent and a demographic form for you to fill out. I will be discussing each point on the consent with you and offer you the opportunity to ask questions and receive a satisfactory answer. Participation in this study is voluntary.

Once we have completed the consent to your approval. I will ask you to fill out the demographic information. After the demographic sheet is completed, we will start the interview. I anticipate that the interview will take an hour to an hour and one-half of your time. I will be tape-recording our conversation.

I will provide you a copy of your consent. In addition, I will locate you within the next few days to have you confirm the transcript of your interview.

You will have 24 hours to withdraw from the study if you decide not to participate.

Sincerely,

Suzanne Goetz, PhD Candidate, MSN, CCS-P

Good Samaritan Health Systems
IRB Approved: 2/26/14
Expires: 2/26/15

Perceptions Toward a Restraint-Free Hospital

Appendix M

Non-Disclosure Form

University of Phoenix®

Non-Disclosure Agreement

Top Tier Editing LLC acknowledges that in order to provide the services to Suzie Goetz (hereinafter "Researcher") who is a researcher in a confidential study with the University of Phoenix, Inc., Top Tier Editing LLC must agree to keep the information obtained as part of its services (as more fully described below) confidential. Therefore the parties agree as follows:

1. The information to be disclosed under this Non-disclosure Agreement ("Agreement") is described as follows and shall be considered "Confidential Information":
   Doctoral dissertation. All information shall remain the property of Researcher.

2. Top Tier Editing LLC agrees to keep in confidence and to use the Confidential Information for editing and scientific evaluation only and for no other purposes.

3. Top Tier Editing LLC further agrees to keep in confidence and not disclose any Confidential Information to a third party or parties for a period of five (5) years from the date of such disclosure. All oral disclosures of Confidential Information as well as written disclosures of the Confidential Information are covered by this Agreement.

4. Top Tier Editing LLC shall upon Researcher's request either destroy or return the Confidential Information upon termination of this Agreement.

5. Any obligation of Top Tier Editing LLC under this Agreement shall not apply to Confidential Information that:

   a) Is or becomes a part of the public knowledge through no fault of Top Tier Editing LLC;
   b) Top Tier Editing LLC can demonstrate was rightfully in its possession before disclosure by Researcher/ research subjects; or
   c) Top Tier Editing LLC can demonstrate was rightfully received from a third party who was not Researcher/research subjects and was not under confidentiality restriction on disclosure and without breach of any nondisclosure obligation.

6. Top Tier Editing LLC agrees to obligate its employees or agents, if any, who have access to any portion of Confidential Information to protect the confidential nature of the Confidential Information as set forth herein.

7. Top Tier Editing LLC shall defend, indemnify and hold the Researcher and the University of Phoenix harmless against any third party claims of damage or injury of any kind resulting from Top Tier Editing LLC use of the Confidential Information, or any violation of by Top Tier Editing LLC of the terms of this Agreement.

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8. In the event Top Tier Editing LLC receives a subpoena and believes it has a legal obligation to disclose Confidential Information, then Top Tier Editing LLC will notify Researcher as soon as possible, and in any event at least five (5) business days prior to the proposed release. If Researcher objects to the release of such Confidential Information, Top Tier Editing LLC will allow Researcher to exercise any legal rights or remedies regarding the release and protection of the Confidential Information.

9. Top Tier Editing LLC expressly acknowledges and agrees that the breach, or threatened breach, by it through a disclosure of Confidential Information may cause irreparable harm and that Researcher may not have an adequate remedy at law. Therefore, Top Tier Editing LLC agrees that upon such breach, or threatened breach, Researcher will be entitled to seek injunctive relief to prevent Top Tier Editing LLC from commencing or continuing any action constituting such breach without showing or providing evidence of actual damage.

10. The interpretation and validity of this Agreement and the rights of the parties shall be governed by the laws of the State of New York.

11. The parties to this Agreement agree that a copy of the original signature (including an electronic copy) may be used for any and all purposes for which the original signature may have been used. The parties further waive any right to challenge the admissibility or authenticity of this document in a court of law based solely on the absence of an original signature.

IN WITNESS WHEREOF, each of the undersigned has caused this Agreement to be duly executed in its name and on its behalf:

Printed Name of Third Party Vendor: Joseph Giardino, Top Tier Editing LLC

Signature: _____
Address: P.O. Box 20097, New York, NY 10023
Date: 9/4/14

Printed Name of Researcher: Suzanne Goetz

Signature: Suzanne Goetz
Address: 2107 West 35th St.
Date: Kearney, NE 68845

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Author Biography

Suzanne Goetz currently lives in Nebraska, in the south central portion, located between Lincoln/Omaha and Colorado/Wyoming. She is married with one teenager. She has been in Nebraska since 1999, from Washington State. Her roots are in the Mid-west and wanted to be closer to family and friends.

Suzanne has been a Registered Nurse since 1984. In 1990, she graduated with a Bachelors of Science in Nursing from Briar Cliff University. She completed her Master of Science in Nursing degree in Minnesota. Her passion has been to finish this Doctor in Nursing Philosophy program. She is striving to be a Nurse Scientist and Health Futurist.

The versatility of nursing has allowed Suzanne to practice in many areas including inpatient, outpatient, orthopedics, detoxification, eating disorders, chemical dependency, at a migrant farmworkers clinic, children, adults, quality, case management, utilization review, research, coding and billing, teaching, risk management, quality assurance, infection control, and multiple others. She is currently a Clinical Educator and Nurse Researcher at Good Samaritan Hospital and Faculty at the University of Phoenix, teaching Nursing Research and Evidence-Based practice.

Suzanne has presented at research and evidence-based practice projects on the topics of Caring Rounds, Violence Prevention, Missed Care, Evidence-Based Practice Models, Publishing, and Principles of Recovery. She published an article April 2012 in the Journal of the American Psychiatric Nurses Association on violence reduction. Her professional service extends to committees for the American Psychiatric Nurses Association, International Society of Psychiatric-Mental Health Nursing. Suzanne

volunteers for the Kearney area Animal Assisted Therapy program, her local school system, and at community events.