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Title

Nursing assistants' experiences of administering manual restraint for compulsory nasogastric feeding of young persons with anorexia nervosa

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Abstract

Manual restraint, a type of physical restraint, is a common practice in inpatient mental health settings linked to adverse physical and psychological staff and patient outcomes. However, little is known about the use of manual restraint for compulsory nasogastric feeding of patients with anorexia nervosa within inpatient eating disorder settings. The present phenomenological study aimed to explore nursing assistants' experiences of administering manual restraint for compulsory nasogastric feeding of young persons with anorexia nervosa. The study followed COREQ guidelines. Eight semi-structured interviews were conducted with eight nursing assistants from one UK inpatient child and adolescent eating disorder service. Interviews were transcribed verbatim and analysed using Thematic Analysis. Three themes were extracted: An unpleasant practice, Importance of coping, and Becoming desensitised and sensitised. Nursing assistants commonly experienced emotional distress, physical exhaustion, physical injury and physical aggression as a result of their manual restraint use. Nursing assistants appeared to cope with their distress by talking with colleagues and young persons who were further in their recovery, and by detaching themselves during manual restraint incidents. The findings highlight that the use of manual restraint for compulsory nasogastric feeding of young persons with anorexia nervosa in the UK, is a highly distressing practice for nursing assistants. It is therefore important that sufficient supervision, support and training is made available to staff working in these settings.

Keywords: Anorexia Nervosa, Inpatients, Mental Health Nursing, Physical Restraint

Introduction

Manual restraint is a form of physical restraint practice, used particularly within inpatient mental health settings, whereby one or more persons restrict the movement of another by manually holding them (Stewart *et al.*, 2009; Stubbs & Paterson, 2011). This differs from mechanical physical restraint which refers to the use of devices (e.g., belts or cuffs) to restrict movement (Care Quality Commission, 2018). Manual restraint is commonly used in conjunction with seclusion and chemical restraint to prevent harm to patients and staff, or to administer medications and other treatments (Chapman *et al.*, 2016; Hawkins *et al.*, 2005; Ryan & Bowers, 2006). For instance, the literature has highlighted the use of manual restraint in response to patient self-harming, aggressive and attempted absconding behaviours (Bowers *et al.*, 2015), and patient medication refusal (Owiti & Bowers, 2011). Concerns have been raised about manual restraint use (Mind, 2013), and international guidelines and programmes advocating for its reduction have emerged (e.g., Department of Health, 2014; Mental Health Commission, 2014; O'Hagan *et al.*, 2008; Royal Australian and New Zealand College of Psychiatrists, 2016). Within England alone, over 50,000 incidents of manual restraint were recorded between the years of 2016 and 2017 in National Health Service funded secondary mental health, learning disability (LD) and autism services (Collinson, 2017), demonstrating the commonality of manual restraint practice. This study explores nursing assistants' experiences of administering manual restraint for compulsory nasogastric feeding (CNF) of young persons with anorexia nervosa (AN).

Background

The literature has highlighted the numerous adverse physical and psychological staff outcomes as a result of manual restraint use. Staff have reported experiencing physical exhaustion, physical pain and injury, and numerous unpleasant emotions (e.g., anxiety, fear, anger) as a result of administering manual restraint (Bigwood & Crowe, 2008; Bonner *et al.*, 2002; Chapman *et al.*, 2016; Sequeira & Halstead, 2004; Wilson *et al.*, 2017). Manual restraint has also been linked to staff feelings of internal conflict, as staff may perceive the act of manually restraining patients as incongruent with their therapeutic role (Bigwood & Crowe, 2008; Chapman *et al.*, 2016; Sequeira & Halstead, 2004; Wilson *et al.*, 2017). Although manual restraint is commonly administered within inpatient mental health settings (Stewart *et al.*, 2009; Wilson *et al.*, 2017), the literature has also illustrated its use within the emergency department, LD services, and paediatric general hospital and residential childcare settings (Chapman *et al.*, 2016; Fish & Culshaw, 2005; Lombart *et al.*, 2019; Steckley & Kendrick, 2008; Svendsen *et al.*, 2017). The manual restraint of young persons raises ethical

and moral issues for staff, and this has been evidenced by the distress and internal conflict staff may experience when manually restraining young persons (Lombart *et al.*, 2019; Steckley & Kendrick, 2008; Svendsen *et al.*, 2017). For instance, staff have reported feeling guilty when restraining children for medical procedures, with some describing how “difficult and demanding” the process can be (Lombart *et al.*, 2019; Svendsen *et al.*, 2017). Presently, little research has been conducted on the use of manual restraint within child and adolescent settings. However, even less research has been conducted on the use of manual restraint for CNF of patients with AN within inpatient eating disorder settings.

AN is an eating disorder characterised by an extremely low body weight, a severe restriction of food, a strong desire to be thin, and an intense fear of gaining weight (National Institute of Mental Health, 2018). Under relevant mental health legislation, patients with AN can be administered CNF in extreme cases when they are presenting with very low body weight, and refusing to eat and/or drink (Fuller *et al.*, 2019; Royal College of Psychiatrists, 2014). In the rare case when a patient is resistant to nasogastric feeding, staff members may administer manual restraint to ensure the safety of themselves and the patient during feeding (Fuller *et al.*, 2019, 2020; Neiderman *et al.*, 2001). Within the UK, manual restraint in this context may be used in the absence of other restrictive practices (e.g., seclusion), and may involve holding the patient’s arms, legs and head in a safe position, in order to allow for the safe passing of a nasogastric tube and subsequent feeding (Fuller *et al.*, 2019; Neiderman *et al.*, 2001). Feeding in the context of active resistance is a rare event and raises ethical, legal and clinical issues for all those involved (National Collaborating Centre for Mental Health, 2004).

Despite the wealth of research that exists on the treatment of AN, we could only locate one published qualitative study that explored the experience of CNF in the context of AN, including the experience of CNF under manual restraint (Neiderman *et al.*, 2001). In this qualitative survey study exploring children and adolescent patients’, and their parents’ experiences of nasogastric feeding, the authors summarised patients’ nasogastric feeding experiences into two main categories: “I regretted it at the time but think that it was necessary” and “I hated it then and hate it now”. This study however did not focus specifically on the practice of CNF under manual restraint, and did not use in-depth qualitative data collection methods such as individual interviews (the authors used qualitative questionnaires). Studies specifically exploring the experience of CNF under manual restraint from either the patient or staff member’s perspective using in-depth data collection methods, could provide valuable insight into this under-researched practice.

The purpose of this study is to explore nursing assistants' experiences of administering manual restraint for CNF of young persons with AN. The research question guiding this study is "How do nursing assistants experience the practice of manually restraining young persons with AN for CNF?"

Methods

Design

We adopted a qualitative methodology to allow for an in-depth exploration of nursing assistants' experiences of a phenomenon that remains under-researched. Our study was underpinned by Husserl's (1970) descriptive phenomenology which seeks to identify the essences of an experience as it is perceived by participants. This approach requires that researchers make efforts to "bracket" and set aside their preconceptions of the phenomenon under study (Husserl, 1970; Langdridge, 2007), in order to stay close to participants' voices during analysis. We felt that adopting this approach was appropriate and important in improving credibility given [MK's] lived experience of administering manual restraint for CNF of patients with AN.

Ethical approval was obtained from the University of Westminster Ethics Committee, and written permission to conduct the study was obtained from the senior management of the eating disorder service in which our participants were recruited. This study followed the COREQ guidelines for comprehensive reporting of qualitative studies (Tong *et al.*, 2007).

Participants and Recruitment

Participants were a purposeful sample of eight permanent nursing assistants and represented the nursing staff members who would typically administer manual restraint for CNF within the eating disorder service. Their ages ranged from 23 to 36 years (mean = 27 years), and their experience of working within the eating disorder service ranged from 5 to 36 months (mean = 20 months). Four were men and the majority of them identified as "White European" or "White British". Being nursing assistants, none of the participants held nursing degrees or diplomas. However, the majority of them held undergraduate and masters degrees in related subjects including Psychology and Biology, and one was studying for a degree in mental health nursing. All participants were supervised by a registered mental health nurse, and had completed at least two days of training in the safe holding and manual restraint of children and adolescents for CNF interventions as per the eating disorder service policy. Within the UK, it is common for graduates of non-nursing degrees (e.g., psychology) who are wishing to pursue a career in mental health (e.g., clinical psychology) to first start out

working as healthcare and nursing assistants in mental health settings to gain relevant clinical experience.

Participants were recruited from a private 25-bed locked inpatient specialist child and adolescent eating disorder service in the UK which provides inpatient treatment to young persons aged 9-18 years with eating disorders. In addition to providing multidisciplinary input from a number of professionals including psychiatrists, paediatricians, psychologists, family therapists and dieticians, the eating disorder service, under the powers of the Mental Health Act 1983 (Department of Health, 2015), and occasionally parental consent, also provides CNF under manual restraint as an intervention to young persons with AN presenting with ongoing food and/or fluid refusal and subsequent non-compliance with nasogastric feeding. A standard CNF intervention under manual restraint within the eating disorder service could typically last between 10 and 30 minutes, and involve up to five nursing assistants restraining the young person in the seated position, and up to two registered mental health nurses inserting the nasogastric tube, checking the tube's placement, and delivering subsequent dietary nutrition through the tube via syringe. As reported by participants, up to 12 CNF interventions under manual restraint could occur per shift within the eating disorder service. This was owing to the fact that some young persons had care plans in place for pre-planned CNF interventions under manual restraint to be implemented multiple times per day (e.g., at specific times during the mornings, afternoons and evenings) due to their global and ongoing refusal of all foods and fluids, and their non-compliance with nasogastric feeding. Chemical restraint was not routinely used within the eating disorder service, and there was a service policy in place for CNF interventions under manual restraint to be aborted and re-attempted at a later time in circumstances where it was not possible to safely administer nasogastric feeding within 30 minutes of manual restraint holds being applied.

Participants were initially approached by [MK] at the beginning or end of their shift who informed them of the study. Those that showed an interest were given a participant information sheet providing further information and participation details. All nursing assistants who agreed to participate provided their informed consent by signing consent forms. Despite having lived experience of manual restraint for CNF of patients with AN, we felt that [MK] was best placed to recruit participants given his affiliation with the eating disorder service as a night shift nursing assistant at the time of the study.

Data Collection

Individual face-to-face semi-structured interviews were conducted by [MK] and lasted between 45 and 130 minutes (mean = 78 minutes). We chose this method of data

collection to allow for an in-depth exploration of our participants' experiences. All interviews were conducted at the University of Westminster in privately booked rooms to ensure the anonymity of participants, although we acknowledged that total anonymity was not possible due to [MK's] affiliation with the eating disorder service.

Our interview schedule included prompts and covered the following topics: the process and experience of administering manual restraint for CNF (e.g., "Tell me about a typical time where you were involved in manually restraining a young person for CNF?"), the impact of this practice on the staff-patient therapeutic relationship ("Tell me about the relationship you have with the young persons who you routinely restrain for CNF?"), and participants' perceptions of this practice ("Tell me about your thoughts towards the use of manual restraint for CNF of young persons with AN?").

Rapport was easily established within interviews, and participants were extremely forthcoming in their narratives, providing extremely rich data about their experiences with reference to personal examples. Consequently, we identified that data saturation had been achieved after the seventh interview (as evidenced by re-appearing concepts and themes), although we had not initially planned to conduct interviews until data saturation. Given that reaching saturation is considered important to the credibility of thematic analysis-driven qualitative research (Ando *et al.*, 2014), an eighth interview was conducted to confirm data saturation. All participants reported that they had found the interview helpful and reflective, and none appeared or reported feeling distressed or burdened by the interview. All interviews were audio-recorded and transcribed verbatim by [MK], and any potentially identifying information was removed from transcripts.

Data Analysis

[MK] conducted an inductive thematic analysis guided by Braun and Clarke's (2006) six step methodology: familiarisation through transcription and repeated reading of transcripts; coding, which was done case-by-case; generating themes and subthemes; reviewing themes; defining and naming themes and subthemes; and writing up the report, during which part, participant extracts were embedded within an analytical narrative. We chose this method of data analysis as we felt that the data driven process of inductive thematic analysis would help [MK] "bracket" his preconceptions and thus maintain rigor with the descriptive phenomenological approach. The use of inductive thematic analysis with descriptive phenomenology, particularly in relation to nursing and midwifery research, has been described in the literature (Sundler *et al.*, 2019).

MK refined the extracted themes and subthemes of the analysis several times following discussions with [JM] and [NS] who were both experienced in qualitative research and who both did not have lived experience of manual restraint use. These discussions, along with the reflexive diary MK kept during the research process, and the use of inductive thematic analysis, were part of the “bracketing” process and were implemented to ensure [MK] stayed close to participants’ voices during analysis. This was particularly important in relation to the credibility of the analysis given [MK’s] lived experience of the research phenomenon. To further improve credibility, we took the completed written analysis to each of our participants, and all confirmed that the analysis had accurately captured their experiences.

Results

Three themes were extracted from the analysis: An unpleasant practice, Importance of coping, and Becoming desensitised and sensitised. It is important to consider these themes in relation to the 5-36 month difference within the experience level of nursing assistants.

An Unpleasant Practice

Administering manual restraint for CNF of young persons with AN was an unpleasant practice for all nursing assistants, and this was evidenced by the numerous reported adverse physical, psychological and interpersonal outcomes. Some felt that they did not receive enough support from the eating disorder organisation in managing these outcomes. Six subthemes are reported.

Emotional distress. Despite recognising the necessity of CNF under manual restraint for young persons with AN who were refusing all foods and/or fluids, seven of the eight nursing assistants described the emotional distress they experienced as a result of administering manual restraint. Some described the practice as “traumatising” both for themselves and the young person; this was predominately attributed to the coercive nature of the practice and the young person’s distressing response to it, which typically included active resistance, aggression, screaming, coughing, complaints of discomfort, and occasional nasal bleeding from nasogastric tube insertion:

It’s scary, it’s emotionally draining for both the patient and staff . . . there’s blood coming out [from the young person’s nose], the child is screaming down the place, so as much as you’re supporting the child, it becomes very difficult because it seems like you’re either attacking or physically punishing somebody. (Participant 2)

Seven nursing assistants reported experiencing a range of unpleasant emotions as a result of applying manual restraint for CNF. Anxiety, guilt and anger were commonly cited

emotions. Participants felt anger, often, in response to being hurt by the young person during restraint, and the young person's lack of cooperation. Anxiety and guilt were commonly attributed to the unpredictability and coerciveness of manual restraint respectively:

Before I go into a restraint, my heart starts pumping a bit more . . . I feel very anxious because we don't know what could happen. (Participant 4)

It's really hard not to be like "why are we forcing them for a thousand calories?" and then you start to feel really guilty. (Participant 5)

Physical exhaustion. All nursing assistants described the physical exhaustion they felt in relation to applying manual restraint for CNF, especially in circumstance where the young person was highly resistive. There were multiple manual restraints to perform per shift, and reports of sweating during restraints were not uncommon. At times, the manual restraint continued even after nasogastric feeding had been completed because the young person was either trying to self-harm or purge the liquid supplement they had just been given. This made the whole restraint even more tiring for participants:

Once you've been in a restraint in a feed you just want to be done with it because it's a physical thing, your body's tired, you're hot and sweaty, you're covered in their sweat as well . . . and if someone continues it by trying to purge, it's more tiring than anything else. (Participant 5)

Despite the physical exhaustiveness of using manual restraint, all nursing assistants also reported that the restraint of some young persons involved minimal physical exertion because of their increased compliance and preference to be fed under restraint:

I was restraining her arm and one of her legs, and it wasn't very intense. The patient was going through this process for a very long time, so she was at that stage where she wanted this holding let's say, but she wasn't aggressive or very resistive. (Participant 1)

Patient aggression. All nursing assistants frequently reported being subjected to physical and/or verbal aggression by some young persons during manual restraint use. It appeared from their accounts that these young persons were using whatever means they could, to prevent or stop the restraint, in order to stop or avoid nasogastric feeding. Commonly cited verbal aggression included swearing and shouting. Commonly cited physical aggression included spitting, kicking, scratching, biting, punching and head-butting. Some participants reported being subjected to such physical aggression even when nasogastric feeding had been completed:

We were starting to leave the restraint . . . I was doing the lower part of the legs and I was kind of tilted over and she actually head-butted me on the head . . . the feed's finished but she still lashes out at staff. (Participant 4)

Being on the receiving end of physical aggression elicited reciprocal urges of aggression for two nursing assistants. These urges were cited in the context of self-defence and the participants in question were clear that they did not reciprocate aggression in any form:

One of the patients was trying to dig her nails in my skin and rip whatever I was wearing to protect my arms. . . I hate these moments particularly because I feel I want to hurt the child . . . at that moment you want to hurt them in order to protect yourself. (Participant 1)

Physical injury. All nursing assistants reported sustaining frequent physical injuries as a result of applying manual restraint for CNF. Injuries typically ranged from back pains to bruises and were reportedly sustained by the physical aggression of young persons or through the execution of the manual restraint itself:

When the patient was moving, as we were restraining her, I got thrown at a door handle and that caused quite big bruising on my back. (Participant 8)

Some nursing assistants reported only becoming aware of a sustained injury after they had returned home from their shift:

Sometimes it happens with bruises, like you go home, you haven't realised how you might have sustained this bruise and then you realise . . . or you might feel back pains which you don't really realise when you're in the restraint. (Participant 6)

In addition to back pains and bruises, two participants reported that they had either obtained, or had witnessed their colleagues obtain more severe physical injuries during manual restraints such as dislocated shoulders, head injuries and being kicked in the groin. In all reported instances this was due to the physical aggression of a young person:

For some reason, one of the legs had not been held tightly, and she kicked the nurse who fell over and landed down. That was very scary because the staff banged her head and she got unconscious . . . they had to call an ambulance. (Participant 2)

Pressure and responsibility. Six of the eight nursing assistants voiced feeling pressured and responsible for their colleagues and themselves while applying manual restraint for CNF. These participants appeared to attribute these feelings to their manual restraint performance, which could have a direct impact on their colleagues' ability to effectively restrain, and the overall success of the nasogastric feeding procedure:

You know in every restraint that if you lose your grip and they get a hand through or a leg through, the whole thing's going to go wrong, so you feel responsible . . . If you lose their hand, they'll grab the tube out and then the whole process has to start again . . . you feel the responsibility from all the other staff as well. (Participant 7)

Failure to execute or maintain restraint positions could result in feelings of frustration and failure, and this was explicitly expressed in four nursing assistants' interviews. It appeared that these participants placed a great deal of pressure and responsibility on themselves to execute their designated manual restraint positions.

Conflict with staff. Five of the eight nursing assistants reported experiencing conflict with their colleagues as a result of administering manual restraint for CNF. Conflict typically occurred when participants had failed to execute their restraint positions effectively. Some participants described feeling frustrated at those who were not able to restrain effectively, and some described incidents where their colleagues had made them feel incompetent:

I've had personal occasions where I can't hold the head because I'm just physically not strong enough . . . and depending on the team situation, that's either fine or you can feel a bit useless . . . they [other staff] can be like "Right! We're going to swap you now!" and it can be quite abrupt . . . and your confidence can be a bit knocked by that. (Participant 5)

Importance of Coping

Seven of the eight nursing assistants valued coping, and this was evidenced by the strategies they consciously employed which helped them cope with applying manual restraint for CNF. Coping strategies were typically utilised during and after manual restraint use. Two subthemes are reported.

Detaching the self. Five of the eight nursing assistants reported actively detaching themselves from the process when they were administering manual restraint for CNF. This was predominately described by female nursing assistants and was evidenced through the use of terms such as "zoning out", "shutting off" and "taking my mind off". Detaching the self appeared to be a conscious response used by participants to cope with the adverse psychological outcomes of manual restraint use:

I sort of try to stay focused on what I'm doing during the whole process but sort of try to take my mind out of this as well so that I can cope with it because it's a very stressful procedure so I'm trying to think of something more calming. (Participant 1)

I get to a point when I just shut off and then I'm just staring into nowhere and just trying to remain in the restraint position because it's just too much to take in.

(Participant 8)

For one nursing assistant, detaching the self was a “necessary” coping strategy that guarded against the adverse psychological outcomes that could result from paying attention to the young person’s distress during restraint. Failing to “zone out”, in this participants view, was self-destructive:

It becomes quite emotionally damaging to pay attention too much to what the patients are screaming and shouting about in the feed so I prefer to kind of zone out, it's my coping mechanism . . . it's necessary to zone out and I kick myself if I don't do it because it's just self-destructive not to. (Participant 5)

Talking with others. Six of the eight nursing assistants reported seeking out conversations with their colleagues and young persons who were further in their recovery, after they had been involved in a manual restraint for CNF. For some participants, this appeared to be a method of cheering up through humour:

Sometimes you just need to get away and be lifted up by someone else. If you can bounce off of a staff member it's pretty good...or go to some of the hyper kids, the kids that at the moment are really doing well, and if they're all having banter with each other, you can sort of get brought into it and sometimes you just forget what's just happened in the restraint. (Participant 5)

For other participants conversing with their colleagues was a method of “venting out” after a particularly challenging restraint which had elicited feelings of frustration:

You can vent out amongst each other as the people that have done the restraint. (Participant 3)

Four nursing assistants reported seeking out trusted staff members to confide in. For the majority of these participants this was a method of expressing their feelings, especially in circumstances where they had partaken in a restraint that had upset them:

. . . and then I spoke to a member of staff that I trusted in that situation and it turned out that the same thing had happened to her so it was nice to have that understanding, it made me feel much less alone. (Participant 7)

Becoming desensitised and sensitised

Despite the physical and emotional challenges that encapsulated participants’ experiences of administering manual restraint for CNF of young persons with AN, and unlike the “Importance of coping” theme which described participants’ conscious attempts to cope

with the procedure, five of the eight nursing assistants reported becoming emotionally desensitised to the practice over time. This was an adaptation predominately reported by male nursing assistants through descriptions such as “getting used to it”, becoming “desensitised” and becoming “immune”:

We're kind of immune to the screams, the noises, the fighting, the everything so it's much easier nowadays, if it's done properly and you're not being hurt, it's easy to go through a restraint without feeling very guilty that you're doing anything wrong.
(Participant 2)

For some nursing assistants, this familiarity to the practice of applying manual restraint for CNF appeared to be facilitated by a change in their attitudes towards the practice over time. This attitude change appeared to involve the acceptance of CNF under restraint as something that was necessary, either as part of their job role or for the young person's own safety:

Now it's just what needs to be done, it's what needs to be done because the patient is not taking the responsibility of feeding themselves so we have to take on that responsibility. (Participant 4)

In contrast to becoming desensitised, two nursing assistants reported that they had become emotionally sensitised to the manual restraint procedure. Participating in the restraint had become more emotionally challenging for these participants over time due to the therapeutic relationship they had built with the young person over time:

The first restraints were a lot easier because I didn't have a connection with the patients, whereas the later on it's got, the more connection I have with the patients, the more worried I am, and the more emotionally demanding it is. (Participant 5)

Discussion

The purpose of this phenomenological study was to explore nursing assistants' experiences of administering manual restraint for CNF of young persons with AN. The findings paint a physically and emotionally distressing picture of the participants' experiences and provide valuable insight into the experience of applying manual restraint for CNF of patients with AN.

It is clear from the analysis that administering manual restraint for CNF of young persons with AN was a distressing practice for nursing assistants. The practice elicited numerous unpleasant emotions including anxiety, guilt and anger, and a small number of participants described becoming emotionally sensitised to the practice over time. Although the majority of participants expressed becoming emotionally desensitised to the manual

restraint procedure, their accounts were often contradictory, suggesting that they had not necessarily become desensitised to the practice. These findings are in line with that of previous studies of staff's manual restraint experiences in both child and adolescent, and adult consumer settings, which have also highlighted the experience of distress and numerous unpleasant emotions as a result of administering manual restraint (e.g., Bigwood & Crowe, 2008; Bonner *et al.*, 2002; Chapman *et al.*, 2016; Lombart *et al.*, 2019; Sequeira & Halstead, 2004; Steckley & Kendrick, 2008; Svendsen *et al.*, 2017; Wilson *et al.*, 2017).

It is not surprising that the theme "Importance of coping" was extracted from the analysis, given the illustrated adverse physical and psychological staff consequences that could result from applying manual restraint for CNF of young persons. The majority of nursing assistants described consciously detaching themselves from manual restraint incidents as a means of coping with the distress it elicited. Detaching oneself appeared to serve a protective function for participants, somewhat safeguarding them against the experience of distressing emotions; this is in line with the findings of previous studies in both child and adolescent, and adult consumer settings which have highlighted how some staff "switch off" their feelings or "temporarily suspend" their ability to empathise with patients during manual restraint incidents (Lombart *et al.*, 2019; Sequeira & Halstead, 2004). Talking with colleagues and young persons who were further in their recovery were also cited by nursing assistants as coping strategies. These strategies appeared to help nursing assistants regulate their emotions through humour (e.g., "banter"), and through cathartic processes (e.g., "venting out"). Staff participants from previous studies of manual restraint within adult mental health settings have similarly highlighted the importance of colleague support in coping with restraint use (Bigwood & Crowe, 2008; Bonner *et al.*, 2002; Sequeira & Halstead, 2004). However, this finding has not been explicitly reflected in studies within child and adolescent settings (e.g., Lombart *et al.*, 2019; Steckley & Kendrick, 2008; Svendsen *et al.*, 2017).

By far the most prevalent finding in this study concerned the adverse physical outcomes that pervaded nursing assistants' experiences of administering manual restraint for CNF of young persons with AN. Nursing assistants were subjected to frequent physical aggression by some young persons, they sustained physical injuries from being physically abused and from executing manual restraints, and they were often physically exhausted from applying manual restraint, typically multiple times during each shift. These findings are in line with previous studies of manual restraint within adult consumer settings which have highlighted the commonality of staff injuries during manual restraint use (Chapman *et al.*,

2016; Lancaster *et al.*, 2008; Southcott & Howard, 2007; Wilson *et al.*, 2017), the physical exhaustion associated with administering manual restraint (Hawkins *et al.*, 2005), and the patient physical aggression staff may be subjected to during manual restraint incidents (Wilson *et al.*, 2017). However, with the exception of one study which reported staff physical exhaustion (Lombart *et al.*, 2019), these findings have not been reflected in previous studies of manual restraint within child and adolescent settings.

An important finding in this study concerned the interpersonal challenges that the majority of nursing assistants reported experiencing including staff conflict, and feelings of pressure and responsibility. In almost all cases, the former and latter experiences were associated with manual restraint performance, that is, the nursing assistants' effectiveness at executing their designated manual restraint positions. Although these findings have not been explicitly reflected in previous studies of staff manual restraint experience, two of the participant extracts in one study within an adult mental health setting, were illustrative of the feelings of pressure and responsibility described by participants in this study (e.g., "they were all there watching, and I am thinking Oh God, have I done this right"; Bigwood & Crowe, 2008, p. 219).

Implications for Practice

In light of the findings of this study, it is crucial that eating disorder services providing CNF under manual restraint sufficiently support their frontline nursing staff. Support can include the implementation of policies ensuring that manual restraints are spread out fairly between nursing staff, so that the same staff members are not repeatedly involved in manual restraint incidents. Support can also include, access to adequate manual restraint training and refresher training, access to adequately sized and ventilated ward areas/rooms for administering manual restraint for CNF, and access to sufficient supervision, post-restraint debriefing, reflective sessions, and talking therapy. Under the close working between psychiatrists, physicians and anaesthetists, it would also be reasonable for relevant eating disorder services to consider the supplementary risk-assessed use of chemical restraint (e.g., oral and parenteral benzodiazepines and oral olanzapine) and mechanical restraint (e.g., restraining belts and soft cuffs) in extreme cases where patients present with ongoing extreme levels of physical aggression and resistance to staff during manual restraints for CNF (Ridley & Leitch, 2019; Royal College of Psychiatrists, 2012, 2014). The aforementioned points are particularly important given the risk of burnout, compassion fatigue and physical injury which may lead to high staff turnover and sickness, and poor standards of care if left unresolved.

It is critical that relevant eating disorder services prioritise the use of psychological interventions, and alternatives to CNF interventions under manual restraint where practically possible, given the highly distressing impact this practice may have on both nursing staff and patients. This can include offering a range of psychological interventions (e.g., art, family, individual and group therapy, etc) and dietary choices to patients (e.g., diverse food types, liquid supplements, etc), with such options frequently being re-communicated to patients who refuse them. The provision of staff training in communication and trauma-informed approaches may help nursing staff develop improved therapeutic relationships with patients (Maguire & Taylor, 2019), which in turn may have an impact on patients' receptiveness towards staff support, their willingness to accept dietary intake, and in turn, their recovery from AN (Sly *et al.*, 2013). CNF interventions under manual restraint should only be used as a last resort after exhaustive unsuccessful attempts have been made to offer oral dietary intake to patients, and there is a clinical need for feeding. This is particularly important for patients who present with ongoing refusal of significant dietary intake, where there may be a risk of the habitual use of manual restraint for CNF as a first resort intervention rather than a last resort.

The findings of this study can be used as a useful source of information for relevant eating disorder services, to illustrate the potential adverse physical, psychological and interpersonal challenges that administering manual restraint for CNF of patients with AN, could pose to their nursing staff. The findings from this study could also be used as a reference for manual restraint for CNF training programmes to highlight the challenges this practice may pose to trainees.

Limitations and Suggestions for Future Research

The participants in this study were recruited from a single inpatient eating disorder service in the UK, meaning that their experiences are likely to have been specific to this service. Caution is thus needed when transferring the findings of this study to other inpatient eating disorder settings. Further research exploring the phenomenon of CNF under manual restraint within different inpatient eating disorder services would be valuable in clarifying the extent to which the experience described in this study is common.

The first author [MK] had lived experience of administering manual restraint for CNF of patients with AN, and conducted all interviews and performed data analysis. Although he maintained a descriptive phenomenological stance throughout, kept a reflexive diary, and made revisions to the analysis following discussions with [JM] and [NS] who both had no lived experience of manual restraint, his lived experience is likely to have had some influence

on the analysis. However, we employed member checking to improve credibility, and all our participants expressed that the analysis had accurately captured their experiences. Notwithstanding, it may be beneficial for future research exploring staff's experiences of CNF under manual restraint to be conducted by researchers who do not have lived experience of this practice, in order to reduce potential bias.

The participants in this study were nursing assistants and thus were not registered nurses. Consideration thus needs to be taken into account of how this participant group may differ to registered nurses, for example, in their training, experience, duties and levels of responsibility. Although the majority of our participants were educated to degree or masters level in related subjects such as Psychology and Biology, and were supervised by registered mental health nurses (so it is likely that they possessed adequate clinical knowledge and skills), the aforementioned points still need to be taken into consideration when transferring the findings of this study to other inpatient eating disorder settings.

Participants all volunteered to participate in this study. Therefore, they were self-selected. Consequently, the participants may have potentially represented those who were more vocal or those with more negative or positive experiences. This needs to be taken into consideration when interpreting the findings of this study.

Conclusion

To our knowledge, this study is the first to explore nursing assistants' experiences of administering manual restraint for CNF of patients with AN, and makes a substantial contribution to the limited literature on this practice. The findings highlight that the use of manual restraint for CNF of young persons with AN is a highly physically and emotionally distressing practice for nursing assistants. It is therefore important that sufficient supervision, support and training is made available to staff working in these settings.

Relevance for Clinical Practice

Eating disorder services that provide CNF under manual restraint as an intervention need to ensure that their frontline nursing staff have access to sufficient support, supervision and training at a minimum, given the adverse physical and psychological staff outcomes that may result from this practice. Such eating disorder services also need to have policies in place that ensure that manual restraints for CNF procedures are spread out fairly amongst staff, especially in services in which this intervention is frequently used.

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