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Research Article

Team Collaboration Experiences of Nurses and Physicians Working in Inpatient Psychiatry Units Related to Physical Restraint Practices: A Qualitative Study

Ayşe Sarı[1], Büşra Ertuğrul[2], Zekiye Çetinkaya Duman[3]

[1]Department of Psychiatric Nursing, İzmir Democracy University Faculty of Health Sciences, İzmir, Türkiye
[2]Department of Midwifery and Health Systems, University College Dublin School of Nursing, Dublin, Ireland
[3]Department of Psychiatric Nursing, Dokuz Eylül University Faculty of Nursing, İzmir, Türkiye

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What is already known on this topic?

- *Physical restraint is a common practice in inpatient psychiatry units, but it has serious physical and psychological risks for both patients and healthcare professionals.*
- *Effective interdisciplinary collaboration, including clear communication and shared decision-making between nurses and physicians, is essential to reducing the use of restraints.*
- *Despite global efforts to minimize physical restraint use, limited research exists in Türkiye on the collaborative experiences of nurses and physicians during the decision-making and implementation process.*

What this study adds on this topic?

- *The study findings highlight nurses' autonomous yet collaborative role in physical restraint practices.*
- *The key facilitators and barriers to the physical restraint process were identified, including the impact of clinical experience, team dynamics, patient communication, staff shortages, and the involvement of patients' relatives.*
- *The study emphasizes the need for structured, evidence-based guidelines to reduce reliance on subjective decision-making and clarify roles within multidisciplinary teams.*

Abstract

AIM: To investigate team collaboration experiences of the nurses and physicians working in inpatient psychiatry units related to physical restraint practices in Türkiye.

METHODS: The present study was conducted in the Adult Psychiatry Inpatient Unit of a university hospital in a province in western Türkiye between May 2022 and January 2023. The study data were collected through 11 individual, face-to-face, semi-structured interviews. The present study has a descriptive qualitative research design. In the analysis of the data obtained from the interviews, the content analysis method was used.

RESULTS: Nurses stated that they play a central role in patient observation and initial intervention during escalating behavior. The formal decision to apply physical restraint was legally attributed to physicians. Participants described the physical restraint process as emotionally and physically distressing, emphasizing that clinical experience, clear communication, and teamwork were essential facilitators, while staff shortages and the presence of uninformed patient relatives posed significant barriers. In the study, the following five main themes emerged: "being a part of the process but not taking part in it, staying a step away from it," "another side of psychiatry—an unpleasant practice," "facilitators," "barriers," and "recommendations."

CONCLUSION: There are uncertainties in the decision-making and implementation processes of physical restraint. These research results affect patient safety in psychiatric inpatient units providing mental health services.

Keywords: Inpatient psychiatry, mental health professionals, nurse, physical restraint, physician, team collaboration

Introduction

Restrictive practices such as physical restraint are used to manage aggressive or violent patients in inpatient psychiatry units. Although implementation of restrictive practices dates back to the beginning of the science of psychiatry, it is still discussed as an application with ethical dimensions that also have negative effects on both patients and healthcare professionals (Muir-Cochrane et al., 2015, 2018). Physical restraint has serious negative effects that can lead to physical injuries, contractures, thromboembolism, and even death (Kersting et al., 2019). Physical restraint also has several psychological effects such as post-traumatic stress disorder, agitation, and hallucinations (Chieze et al., 2019). Given these negative results, it is recommended that primarily, a patient-centered holistic approach should be preferred, and implementation of physical restraint should be reduced (American Psychiatric Nurses Association [APNA], 2022; Muir-Cochrane et al., 2015). Thus, in many countries, programs aimed at reducing the implementation of physical restraint have been developed, and the results of such programs have indicated that the

Corresponding author: Ayşe Sarı
E-mail: aysesar2012@gmail.com

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rate of physical restraint practices can be reduced before they create negative consequences (The National Health Service, 2019). However, physical restraints are still widely used in many countries. In several studies, it has been reported that the rate of using physical restraints in psychiatry units is close to 50% (Muir-Cochrane et al., 2018; Wilson et al., 2018). In Türkiye, the number of studies on the incidence of using physical restraints is very few. Darçın et al. (2017) stated that of the hospitalized patients, 1.9% were physically restrained and 9.4% were subjected to acute drug administration.

Support from all levels of an institution and interdisciplinary collaboration are important determinants in reducing the use of physical restraints in patients (Allen et al., 2009). In the American Psychiatric Nurses Association's (2022) current position statement, it is also stated that encouraging a culture of collaboration rather than "control" in the institution can be decisive in reducing the use of physical restraints (APNA, 2022). Among the attributes of the concept of collaboration in mental health services are qualities such as communication, respect, good understanding of roles, shared decision-making, and common goals (Lam et al., 2017). Nurses working in mental health units have key roles in creating and maintaining a therapeutic environment (APNA, 2022). They play a central role in the provision of mental health care for individuals with mental illness in inpatient psychiatry units, and they share the decision process with the physicians to use physical restraint (Ministry of Health, 2023). In the physical restraint decision process, nurses have negative experiences such as being blamed by their nurse colleagues, having fear and guilt, having relationships affected negatively, and having doubts about their own abilities (Muir-Cochrane et al., 2018). In addition, other team members displaying different approaches toward the use of physical restraint and questioning their decisions may increase conflicts within the team (Green et al., 2018; Muir-Cochrane et al., 2018). In several studies conducted on nurses' decision-making processes, nurses have been determined to have demands. For instance, they want to be supported by a multidisciplinary team and to have roles that are more specific (Muir-Cochrane et al., 2018). There are also uncertainties regarding the roles of psychiatrists in the use of physical restraints in inpatient psychiatric units, which negatively affects the collaboration between psychiatrists and nurses (Masters & Huckshorn, 2020).

The rate of using restraints in a psychiatric inpatient unit is related to the unit's treatment philosophy (APNA, 2022; Kanyeredzi et al., 2019). It has been stated that nurses and psychiatrists perceiving the use of physical restraint as normal is considered a starting point in removing the confusion of this atmosphere, which helps them get rid of the emotional distress they are exposed to (Renwick et al., 2019). Besides, normalizing the use of physical restraint can have harmful effects such as persistent guilt and self-blame in the long term, and can adversely affect relationships in the workplace (Mooney & Kanyeredzi, 2021). Individual experiences are effective in making a decision on physical restraint use; however, as is stated in several studies, the main factor affecting the team decision is the team's understanding (Green et al., 2018; Muir-Cochrane et al., 2018). In a systematic literature review conducted to investigate the factors affecting the use of physical restraints, it was determined that inadequate team communication, education level, and the number of health personnel were identified as effective factors (Butterworth et al., 2022). In another study, it was stated that a lack of respect, flexibility, and role clarity in team members affected the sense of trust and therefore the management of the use of restraints (Snorrason & Biering, 2018). However, nurses' and physicians'/psychiatrists' experiences regarding team cooperation during the physical restraint decision process are not sufficiently clarified in the literature.

The Quality Standards include limited guidance in psychiatric clinics regarding when physical restraint can be applied, informing patients and their relatives, process management, materials to be used, and who can apply it in Türkiye (Ministry of Health, 2020). Besides, apart from the shortage of descriptive studies, there is a gap in the team members' experience in the restraint management process in psychiatric units. Because both the individual and team decisions and the process during which the decision is made are important in the implementation of physical restraint, what should first be first determined in Türkiye are nurses' and physicians /psychiatrists' decision-making process-related experiences, how the process is perceived by the team, the support mechanisms they need in the decision-making process, and their emotional experiences. It is thought that investigating the experiences of the professional team working in the psychiatric inpatient unit regarding physical restraint will help to form a common language in emergency psychiatric interventions. The present study aimed at investigating the collaboration experiences of nurses and physicians working in an inpatient psychiatry unit during the implementation of physical restraint in Türkiye.

Research Question

1. What are the collaboration experiences of nurses and physicians working in an inpatient psychiatry unit in Türkiye during the implementation of physical restraint?

Methods

Design

The consolidated criteria for reporting qualitative research (COREQ) were used in the study (Tong et al., 2007).Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. International Journal for Quality in Health Care, 19(6), 349–357. The present study has a descriptive qualitative research design.

Sample

The present study was conducted in the Adult Psychiatry Inpatient Unit of a university hospital in a province in western Türkiye between May 2022 and January 2023. The hospital where the study was conducted has one inpatient psychiatric unit. In the inpatient unit where the study was conducted, 27 physicians, 6 nurses, and 4 assistant staff worked. Although there is no standard practice/protocol on the management of aggressive patients in the inpatient unit, practices such as physical restraint, isolation, and chemical physical restraint are used in case the patient displays aggressive behaviors.

The purposive sampling method was used in sample selection. The sample of the study consisted of the nurses and the

Table 1.
Descriptive Characteristics of the Participants

Participants	Age (Years)	Sex	Education Status	Profession	Length of Service in the Field of Mental Health	Receiving Training on Physical Restraint
Participant 1	45	Woman	Postgraduate	Nurse	13 years	No
Participant 2	30	Woman	Undergraduate	Nurse	1.5 years	No
Participant 3	53	Woman	Undergraduate	Nurse	29 years	No
Participant 4	27	Woman	Postgraduate	Physician	2 years	No
Participant 5	38	Woman	Undergraduate	Nurse	1.5 years	No
Participant 6	50	Woman	Undergraduate	Nurse	7 years	No
Participant 7	30	Men	Undergraduate	Physician	4 years	No
Participant 8	32	Woman	Postgraduate	Physician	8 years	No
Participant 9	43	Woman	Undergraduate	Nurse	9 years	No
Participant 10	27	Men	Undergraduate	Physician	2.5 years	No
Participant 11	46	Men	Postgraduate	Physician	19 years	No

physicians who worked in the adult psychiatric inpatient unit of a university hospital and met the sampling criteria. The inclusion criteria were as follows: Being over the age of 18, volunteering to participate in the study, working as a mental health professional in inpatient psychiatry units for at least 6 months, and having taken part in the physical restraint application process in aggressive patient management. The interviews continued until the data obtained from the interviews started to repeat and were terminated as the data reached the saturation point (Streubert & Carpenter, 2011). The saturation point was reached at the end of 11 interviews (Table 1).

Data Collection
The study data were collected through individual, face-to-face, semi-structured interviews. The nurses and the physicians who volunteered to participate in the study were informed about the study in detail, and their written and verbal consent was obtained. Interviews were conducted in the mental health professional's room or in the interview room. The same researcher (PhD) conducted the entire interview process, and the interviews were recorded on a voice recorder. Each participant was interviewed once.

Data Collection Tools
The following were used to collect data: the descriptive information form and semi-structured interview questions.

Descriptive Information Form
The form developed by the researchers in line with the literature was used to question the demographic and work-related characteristics of the nurses and the physicians working in the inpatient psychiatry unit, such as age, sex, profession, length of service in the profession, and training status related to physical restraint (Lee et al., 2021; Mahmoud, 2017; Vedana et al., 2018).

Interview Questions
The semi-structured interview questions were prepared to investigate the team collaboration experiences of the nurses and the physicians in physical restraint practice. The five semi-structured interview questions were prepared by the researchers based on their opinions and the relevant literature (McCain & Kornegay, 2005; Muir-Cochrane et al., 2018) The researchers are experienced in both using restraints and conducting qualitative research in psychiatry departments (Table 2).

Statistical Analysis
The data of the descriptive characteristics of the participants were analyzed by number, percentage, arithmetic mean, and standard deviation. In the analysis of the data obtained from the interviews, the content analysis method was used. In qualitative data analysis, the analysis process begins with the start of the data collection process (Streubert & Carpenter, 2011). In the first stage for the analysis of the data, the audio recordings obtained through individual interviews were transcribed verbatim. Then, the transcribed interviews were read several times, and all the interview records were coded in accordance with the purpose. The common codes and the whole text were read several times by two of the three researchers, and the codes forming the meaning integrity were brought together, and the themes and sub-themes were obtained. The same two researchers discussed the themes and sub-themes they obtained independently of each other and reached a consensus (Erlingsson & Brysiewicz, 2017). The opinion of the third

Table 2.
Interview Questions

- Could you tell us about your aggressive patient management experiences during the physical restraint implementation process?
- In what cases do you resort to physical restraint?
- What are your views on "the place (role) of physical restraint in aggressive patient management"?
- What are your experiences regarding your cooperation with the other members of the team during the physical restraint implementation process?
- What are your suggestions regarding cooperation with the other members of the team during the physical restraint implementation process?

Table 3.
Code and Theme Examples for Content Analysis

	Theme 1: Being a part of the process but not taking part in it, staying a step away from it
Codes	• The physician's decision-making on the implementation of physical restraint • The physician's staying a step away from the implementation of physical restraint • The physician's unwillingness to take part in the physical restraint process • The nurse's being at the forefront during the implementation of physical restraint
	Theme 2: Another Side of Psychiatry—An Unpleasant Practice
Codes	• The patient's and mental health professional's being at risk of harm • Other patients' being affected by the physical restraint process • Difficulties experienced by mental health professionals during the implementation of physical restraint

researcher was also obtained at the last stage regarding the final forms of the themes. No data analysis program was used in the analysis of the data. In order to clarify how the themes were created based on the codes, some examples of codes and themes are given in Table 3.

Rigor

To evaluate the rigor of the study, Colorafi and Evans' principles were utilized (2016). In line with the principle of confirmability, the methods and processes of the study were explained in detail. The research data were audio-recorded and transcribed verbatim. In line with the dependability principle, all the interviews were conducted by the same researcher. The same voice recorder was used to record all the interviews. All the participants were asked the same semi-structured interview questions. The analysis of the data in terms of credibility was carried out by two of the three researchers. The two researchers who obtained separate themes through common codes discussed their common/different aspects and reached a consensus on the themes. The researchers who attended national and international courses on qualitative research are experienced in qualitative research, and they have conducted several qualitative studies. The purposive sampling method was used in line with the principle of transferability. All the descriptive characteristics of the participants are given in Table 1. Then the third researcher analyzed the results of the analysis obtained by the two researchers.

Ethical Considerations

Before the study was conducted, ethics committee approval was obtained from the Dokuz Eylül University non-interventional ethics committee (Decision Date: May 18, 2022; Decision Number: 2022/18-12). Institutional permission was also obtained. The purpose and importance of the study were explained to the participants in detail, and they were informed that the interviews would be audio-recorded. Written and verbal consent was obtained from the participants.

Results

The mean age of the participants was 38.27 ± 9.55 years. The mean length of their service in the field of mental health was 8.77 ± 8.65 years (n = 11) (Table 1).

In the study, the following five main themes emerged: "being a part of the process but not taking part in it, staying a step away from it," "another side of psychiatry—an unpleasant practice," "facilitators," "barriers," and "recommendations" (Figure 1).

Theme 1: Being A Part of the Process But Not Taking Part In It, Staying A Step Away From It

The majority of the participants stated that the decision to use physical restraint on the patient was made by the team, that they generally did not have any conflict over the decision, but that legally, it was the physician who had to make the decision. The nurses stated that the patient with a problem or distress first contacted them and that the communication between the patients and the physicians was limited. In this process, the nurses stated that they immediately communicated with the patient and observed the patient in cases when the patient spoke loudly and/or displayed aggressive behaviors, and that the physicians observed the patients less.

The nurses stated that the physicians acted as the coordinators of the process during the decision-making and implementation phases of the physical restraint undergone by the patient and that they did not adequately participate in the practices carried

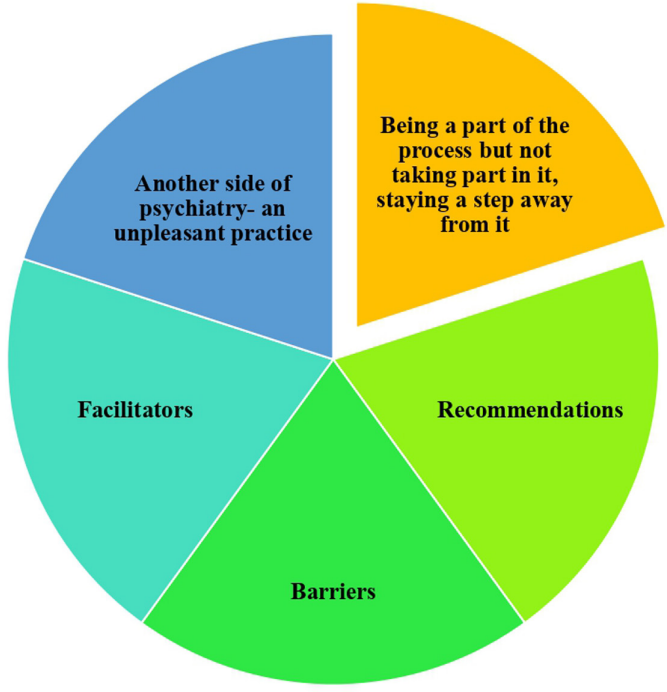

Figure 1.
Themes Related to Team Collaboration Experiences in the Physical Restraint Process.

out during the process. According to one of the nurses, the physicians did not take an active part in the physical restraint process because they were afraid of taking responsibility. Some of the nurses' statements regarding this theme are as follows:

*Of course, if the physician doesn't grab hold of the patient with me, if he doesn't restrain the patient, this makes me nervous; she/he is like a bystander there. While you were struggling there, I experienced it once, one of our patients escaped, I experienced it out the unit, so I was struggling there alone and trying to convince the patient with the help of the other staff … Physician colleagues stayed almost 5 meters away from us and said, "let's administer acuphase. (9th participant, nurse).*Some of the physicians also held the opinion that they should not be involved in the implementation of the restraining process. A physician's statement regarding this is as follows: *"I think we, as physicians, should not be involved in the physical restraint process." (10th participant, physician).*

Theme 2: Another Side of Psychiatry—An Unpleasant Practice

Health professionals mentioned that the restraining process is a negative situation both for them and for the patients and that it is a wearing process bringing about much negativity. The restraining process is defined as a traumatic process in which health professionals try to manage the aggressive patient, and they and other patients who witness the situation may be harmed. One of the participants' statements regarding this theme are as follows: *"Restraining is a very difficult process for us because it occurs in front of many other patients, and we sometimes catch the patient in the corridor, we inject him or her there, and there are cases where we take them to their room by force and use a physical restraint. It is also a very traumatizing scene for other patients. Therefore, physical restraint is a terrible thing for someone who witnesses it. It is very scary both for the person undergoing it and for the person implementing it." (3rd participant, nurse)*

Theme 3: Facilitators

The participants stated that some factors facilitated cooperation in the implementation process of physical restraint. The following three sub-themes emerged under the theme of facilitators: nurse observations, clinical experience, and collaboration with the patient.

Nurse Observations

The participants emphasized that nurse observations played a very important role in the restraining process. Observation is stated as an important practice that is used to determine the decision mechanisms and facilitate cooperation at every stage, from restraining to de-restraining. The participants stated that the physicians were not as familiar terms with the patients as the nurses, and that those who constantly observed the patients were the nurses. One of the participants' statements regarding this sub-theme are as follows: *"… and the observation of the nurse team that day or in the last few days, how the patient is handed over. We, physicians, see the patient for a short time and sometimes the physician on duty sees the patient for a very short time. Because nurses follow up with the patient all day and write down the patient's daily behaviors, they can hand over the patient to each other in more detail." (10th participant, physician)*

Clinical Experience

The participants stated that being experienced in this practice before taking a primary role in the physical restraint process facilitated cooperation in the process. They also stated that even if the patient's need for physical restraint was determined through observation, it might be difficult for an inexperienced person to predict what awaits him or her in the next step and that experience in this regard had a facilitating effect on cooperation. One of the participants' statements regarding this subtheme are as follows: *"I think our experience is important in this sense. In other words, the patient can do anything there, even there is a risk of verbal or physical violence against us, and it is important for the health professional to protect themselves. He or she should predict that the patient can do such a thing and should develop a scenario to save himself or herself, for example, the things that experience brings about." (7th participant, physician)*

Collaboration With the Patient

The participants stated that they always informed the patient before the physical restraint process, that they tried alternative applications that could be applied before the physical restraint process, and that they tried to persuade the patient. Some participants stated that if there were alternatives that could be tried before the physical restraint process, they tended to implement them. Establishing collaboration with the patient in this process is an important facilitator in the physical restraint process. One of the participants' statements regarding this sub-theme are as follows: *"We never apply physical restraint before we tell the patient that we will apply physical restraint and explain what the physical restraint is like. … and we already offer all the alternatives not to apply physical restraint." (8th participant, physician).*

Theme 4: Barriers

The participants stated that factors related to the shortage of health professionals and presence of the patient relatives hindered team cooperation during the implementation of the physical restraint process.

Presence of the patient relatives

During the implementation of the physical restraint process, the presence of the patient relatives can be a hindering factor if they do not have enough information about the procedure. One of the participants stated that patient relatives displayed an emotional approach and did not view the application objectively, which affected their reactions. One of the participants' statements regarding the difficulties in the management of patient relatives is as follows: *"Patients' relatives often display not a supportive but a hindering approach. Sometimes because we, the team, made the decision to apply physical restraint, but the patient's relative insists that he or she does not want such a thing. He or she says, 'I don't want my patient to be restrained,' which is a disadvantage to us." (3rd participant, nurse)*

Shortage of Health Professionals

The participants stated that the number of physicians was not sufficient whether they worked day or night shifts, which caused difficulty in the implementation of the physical restraint process. Some of the participants also said that the security guard of the hospital came late when they needed them and that even if they came on time, they did not support them when the patient had to undergo an intervention. One of the participants' statements regarding this barrier is as follows: *"Usually, there is a shortage of personnel... for example, two or three personnel try to do what should be done by five people. Thus, even if they are experienced, they cannot be in the position they must be, and they have to pay attention to other things at the same time. Therefore, some difficulties may arise." (8th participant, physician)*

Theme 5: Recommendations

The participants suggested the following to increase cooperation in the implementation of the physical restraint process: training, guidelines, and building a physical restraint team. The first two of these recommendations are related to the need for training. The participants in the present study did not receive any training on physical restraint application. Providing training to the entire team on the physical restraint process and its management, and updating the training regularly were among the recommendations. One of the participants' statements regarding training is as follows: *"I think it is possible to give training to the whole team together. Not just to physicians or not just to nurses. I think it would be beneficial for all of us, physicians and nurses, to receive training on this issue." (4th participant, physician).*

Some of the participants also stated the following as a suggestion: The creation of guidelines on this subject would be useful in managing this process. One of the participants' statements regarding this issue is as follows: *"...there may be a certain follow-up schedule... I think all these should be recorded before, during and after the implementation of physical restraint. Not just as patient physical restraint on the computer. The behavior that necessitates physical restraint, the need for physical restraint, treatment offered to the patient, the patient's maladaptive behaviors, and the patient's cooperation all these should be stated clearly and signed both by the physician and by the nurse." (10th participant, physician)*

One participant suggested that a physical restraint team should be built to improve the process. What she meant was that "a team will be ready if the implementation of physical restraint becomes necessary."

Discussion

The team approach in the physical restraint process affects mental health professionals both individually and in terms of group dynamics. In reducing the need for physical restraint, it is important to understand the experiences of the nurses and physicians involved in the process and the dynamics of the team approach (Green et al., 2018; Wilson et al., 2017). It has been emphasized that in Türkiye, nurses working in acute care and inpatient psychiatry units need multidisciplinary team support (Ertuğrul & Özden, 2023). In this sense, there is a gap related to studies in which the physical restraint experiences of nurses and physicians in inpatient psychiatry units in Türkiye have been investigated. The findings of the study was discussed within the framework of five themes that emerged in the study.

Theme 1: Being A Part of the Process But Not Taking Part In It, Staying A Step Away From It

Nurses play a key role in the physical restraint process in terms of both reporting the patient's aggressive behavior and participating in the decision-making process. Although there is uncertainty about the team approach in the literature, it is understood from several studies that the physical restraint application is generally carried out by nurses, consistent with the results of the present study (Krieger et al., 2021; Muir-Cochrane et al., 2018). According to the results of the study, the nurses used their autonomy in the physical restraint process without conflict with the team. Unlike the results, it is stated in the literature that nurses feel guilty towards their teammates due to their decision (Mooney & Kanyeredzi, 2021; Muir-Cochrane et al., 2018).

According to Boumans et al. (2012), a factor affecting a nurse's ability to manage aggressive patients is trust in the team. As stated in several studies in the literature, open communication between group members reduces physical restraint application, and a positive team climate reduces stress and improves coping techniques (Stevenson et al., 2015). Open communication within the team is important in terms of understanding the needs of both the team and the patients, and focusing on methods of reducing tension instead of using physical restraint (Boumans et al., 2012). Confusion in the communication between nurses and physicians can also have a negative impact on health professionals' ability to develop alternative strategies to deal with challenging situations.

Theme 2: Another Side of Psychiatry—An Unpleasant Practice

The participants in the study stated that the team had difficulties during the physical restraint application. Failure to maintain the therapeutic communication environment in psychiatric settings was considered inversely proportional to the patients' belief that they were treated fairly, caringly, and respectfully (Theodoridou et al., 2012). Ethics of medicine and care support the 'collaborative-decision making' approach rather than the paternalistic viewpoint in preserving the autonomy and dignity of the patient while the physical restraint practice is carried out (National Institute for Health and Care Excellence [NICE], 2015). Maintaining and supervising multidisciplinary teamwork has been suggested to alleviate the ethical burden experienced by physicians and nurses (Krieger et al., 2021). From a holistic point of view, if the interaction between the clinician and the patient is to be at the center of therapeutic care, then decisions should include patients, caregivers, families, and nurses (Goulet et al., 2017).

Results of several studies are consistent with the results of the present study, indicating that physical restraint practice has negative effects on nurses and physicians (Goulet et al., 2017; Wilson et al., 2017). Mutual support between the team

members is considered beneficial in coping with the negative emotions and physical effects that develop due to physical restraint application (Green et al., 2018; Wood et al., 2019). Among the recommended practices that enable nurses to cope with this difficult process they experience are providing them with training on concrete topics, such as the basic psychological approach to team reflections after the application of physical restraint, and the establishment of effective communication (Mooney & Kanyeredzi, 2021; Krieger et al., 2021).

Theme 3: Facilitators

The results of the study demonstrated that nurse observations, clinical experience, and cooperation with the patient were the factors that facilitated cooperation in the physical restraint process. Nurse observations are among the basic practices in ensuring patient safety in psychiatric inpatient units (Sari & Çetinkaya Duman, 2017). The NICE (2015) states that the institution should have an observation policy, that the risk of aggression should be evaluated with short, valid, and reliable risk assessment tools, and that a multidisciplinary team should use approach strategies in accordance with the risk level of patients who are at risk of harming themselves and their environment. As indicated in the literature, clinical experience has positive and negative effects on attitudes displayed toward restrictive practices (Krieger et al., 2021). The results of the study support that experience causes a feeling of control and competence in the management of the use of physical restraint and the critical decision-making process to use physical restraint (Krieger et al., 2021; Muir-Cochrane et al., 2018; Wilson et al., 2017). The fact that the team includes members with different levels of experience not only positively affects the team relationship but also reduces the use of physical restraint by paving the way for desired changes (Janssen et al., 2007). Thus, it was recommend that the support, information sharing, and supervision needs of new employees in the team should be met and that they should be provided with evidence-based, information-based training (Green et al., 2018).

The participants in the study stated that they informed the patients before the physical restraint process and tried alternative applications before applying physical restraint. Being able to communicate with the patient is found important in predicting the crisis and high-tension situations of the patient (Boumans et al., 2012). The APNA (2022) supported the idea that, for restraint reduction, the prevention of aggression through collaboration rather than control is key. According to the results of the study, consistent with those in the literature, the physicians and nurses acted within the framework of the 'paternalistic' perspective on behalf of the patient rather than making a joint decision with the patient in the decision process (Aasland et al., 2018).

Theme 4: Barriers

In the hospital where the present study was carried out, patients were allowed to have a relative stay with them in the unit when they needed one. Patient's relatives are mostly allowed in cases when patients are at risk of harming themselves or have difficulties maintaining their self-care during their hospitalization because, in such cases, they require close observation. However, the participants stated that, in the case of the risk of aggression, which is one of the risky situations, the patient should be restrained. Generally, the patient's relative is not emotionally ready for such a process and thus they may hinder it. In a study all the nurses and physicians stated that patients' relatives who accompanied them reduced the burden on the team in risky situations, but half of them also stated that the presence of the patient relatives negatively affected the process (Çetinkaya Duman et al., 2015). Unlike the results of the present study, in another study, one-fourth of the nurses stated that the patients' relatives should have the right to refuse physical restraint application (Lee et al., 2021). In the literature, there are also studies in which caregiver family members perceived the use of physical restraint as "normal" and considered it an acceptable practice (Gowda et al., 2019; Kuppili et al., 2022).

In the literature, it is also stated that a shortage of health professionals has a negative effect on the use of physical restraints (Janssen et al., 2007) because the more professionals involved in the process, the better the patient assessment is performed (Boumans et al., 2012). Another negative consequence of staff shortage is that physical restraint becomes a 'routine' practice over time (Mooney & Kanyeredzi, 2021; Muir-Cochrane et al., 2018). Therefore, it is recommended to allocate enough employees to prevent such negativities.

Theme 5: Recommendations

Early detection of harmful patient behaviors and rapid response in inpatient psychiatry units can be achieved with the multidisciplinary team decision (Whitecross et al., 2020). Training of health professionals and risk identification were also considered effective methods in reducing physical restraint use in Hirsch and Steinert's study (2019). It has also been reported that the lack of education leads to an increase in the use of physical restraint and that training for health professionals could reduce such use (Goulet et al., 2017; Muir-Cochrane et al., 2018; Janssen et al., 2007). In addition to the existing treatment directives on the use of physical restraint, structured evidence-based guidelines are needed. It is seen that the process is managed according to subjective decisions, as found in other studies (Boumans et al., 2012). The development of evidence-based guidelines is needed to prevent both differences between individual decisions and the role confusion of the nurses and physicians that develops during the implementation process.

Study Limitations

Since the focus in the present study was on the identification of teamwork associated with the implementation of physical restraint, the focus was not on the basic needs for routine practices associated with the use of physical restraint. The data for the study were collected from the nurses and physicians who participated. The issue was not investigated from the team approach, patient, and caregiver family member perspectives.

Conclusion and Recommendations

The results of the present study reflect the situation regarding nurse and physician relations in the use of physical restraint in psychiatric inpatient units in Türkiye. It was observed that there were uncertainties in the decision-making and implementation processes of physical restraint. The results of the our study

indicate that institutional and legal regulations should be prepared to support teamwork in the use of physical restraint in psychiatric inpatient units in Türkiye. The results of the present study also indicated that clarification of the job descriptions in the implementation process of physical restraint, and the creation of protocols and documents on how the implementation process will be carried out were among the important needs. It is obvious that there is a need for studies in which a multidisciplinary team approach is adopted in order to reduce the use of physical restraint in psychiatric inpatient units.

Availability of Data and Materials: The data that support the findings of this study are available on request from the corresponding author.

Ethics Committee Approval: Ethics committee approval was received for this study from the Ethics Committee of Dokuz Eylül University (Decision Number: 2022/18-12, Decision Date: May 18, 2022).

Informed Consent: Written and verbal informed consent was obtained from the participants who agreed to take part in this study.

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