A Hermeneutic Phenomenological Exploration of Nurses' Experience: Positive Behaviour Support

Professional Doctorate in Health and Social Care

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Statement

I confirm that this thesis is my own work and that I have received regular academic supervisions to develop it to this stage. I have included three published works that contain aspects of my research; and one paper that was accepted for publication in February 2022. I have detailed each paper individually below including those to which other writers have contributed.

- Savarimuthu, D. (2020). The potential role of nurses in leading positive behaviour support. *British Journal of Nursing*, 29(7), pp.414-418. This paper includes parts of my study and no other writer contributed to it. It is to be noted that sections directly related to my study appear in my thesis.

- Savarimuthu, D. (2019). Positive behaviour support: exploring the experiences of nurses. *Mental Health Practice*, 24(3). No other writers contributed to its drafting. Parts of this paper appear in my thesis as it is directly related to my study.

- Savarimuthu, D. and Jung, K. (2021). A quality improvement project to reduce restrictive interventions in a mental health service. *British Journal of Mental Health Nursing*, 10(2), pp.1–12. This paper is not directly related to my doctoral study. I am the main author of this paper and was heavily involved in its drafting, review, and submission for publication. This paper describes and explores the use of evidence-based interventions such as Positive Behaviour Support (PBS) and the Safewards Model in reducing restrictive interventions on a mental health ward.

- Savarimuthu D, Mullobux S, Newblow J, Opoku B. Exploring the experiences of student mental health nurses from ethnic minority backgrounds working through the COVID-19 pandemic: a phenomenological approach. British Journal of Mental Health Nursing. 2022. https://doi. org/10.12968/bjmh.2021.0028. I am the main author of this paper and conducted the interviews and interpretation of the transcripts. Three other contributors were involved in the recruitment of participants. This paper offers an understanding of the experiences of student nurses from an ethnic minority group in relation to the Covid-19 pandemic.

Acknowledgement

First and foremost, I am indebted to the registered nurses and colleagues who gave their time in this research amid the Covid-19 pandemic. Of course, without those participants this project would have remained unfinished. To all the service users with whom I have worked over the years: you have given me the experience and education that influenced my interest in this subject; so, thank you!

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1.0 Abstract

This thesis explores the experience of registered nurses in relation to Positive Behaviour Support (PBS) in a mental health organisation. PBS has developed into an important, effective, and useful framework in delivering care for individuals with learning disability and mental health issues. Its use started in specialist schools, but it has gradually progressed into learning disability services, and evidence now suggests that PBS is being considered in mental health services for individuals with mental illnesses. However, it is evident that registered nurses' views of PBS, as an autonomous group, is missing from current literature. Therefore, the aims of this study are: to explore these nurses' experience, including their knowledge and understanding of PBS; to generate new knowledge and contribute towards the existing body of evidence on PBS; to explore any evidence in the current literature concerning nurses' experience, knowledge and understanding of PBS; and to address any identified gaps. It also explores the findings and makes recommendations towards the advancement of employing PBS in a mental health context. Further, it aims to identify support that nurses would require to embed PBS in their day-to-day practice.

The study has used 19 individual interviews as its data collection method. Data analysis adopted hermeneutic phenomenology, which is a theoretical and philosophical framework that helps understand and explore individual lived experience and phenomena. The computer software NVivo version (11) mainly assisted with storage and organisation of the transcripts. Six themes emerged from the study: (i) training, (ii) resources, (iii) psychology-led practice, (iv) restrictive interventions, (v) communication, and (vi) effectiveness of a new construct. Participants described PBS as an effective framework that is supportive to people who use services. They believed experience, knowledge, and training in PBS support to be a consistent delivery approach. Nurses were of the view that appropriate communication and leadership are essential elements for effective PBS practice. However, it is suggested that a lack of resources could potentially compromise the framework's delivery and efficacy. Further, while PBS helps the reduction of restrictive interventions it was observed to be mostly psychology-led. The findings of this study clearly position nurses as key stakeholders at the centre of PBS delivery and in supporting service users in their recovery.

Glossary of Terms

ABA: Applied Behaviour Analysis

ABC: Antecedent, Behaviour and Consequence

ASD: Autistic Spectrum Disorder

BILD: British Institute of Learning Disabilities

CAMHS: Child and adolescent Mental Health Service

CASP: Critical Appraisal Skills Programme

CBT: Cognitive Behaviour Therapy

CINAHL: Cumulative Index of Nursing and Allied Health Literature

Consumer: a person obtaining treatment or support for a mental disorder; also known as psychiatric or mental illness.

CoP: Code of Practice

CQC: Care Quality Commission

DH: Department of Health

DBT: Dialectical Behaviour Therapy

GDPR: General Data Protection Regulation

HEE: Health Education England

MDT: Multi-disciplinary team

NHS: National Health Service

NMC: Nursing and Midwifery Council

MH: Mental Health

MMAT: Mixed Methods Appraisal Tool

OT: Occupational Therapist

PBS: Positive Behaviour Support

PICU: psychiatric Intensive care Unit

PRISMA: Preferred Reporting Items for Systematic Review and Meta-Analyses.

PRN: *Pro re nata* (as and when required)

QDAS: Quantitative Data Analysis Software

QI: Quality Improvement

QoL: Quality of Life

REC: Research Ethics Committee

RCN: Royal College of Nursing

RMN: Registered Mental Health Nurse

RNLD: Registered Nurse Learning Disabilities

Service User: a person who uses services; a person with lived experience

TA: Thematic Analysis

UK: United Kingdom

LD: Learning Disability

WHO: World Health Organisation

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2.0 Introduction and Background

2.1. Introduction to chapter

This study seeks to explore and understand registered nurses' experience of Positive Behaviour Support (PBS) in a mental health and learning disability context. Therefore, this introductory chapter provides both introduction and background to the study, including an overview of the different chapters, establishing the researcher's underpinning motivation, and offers an understanding of the PBS framework and its effectiveness. In this chapter and throughout the thesis, the term 'nurse' or 'nurses' will refer to registered nurses on the Nursing and Midwifery Council (NMC).

2.2 Overview

This thesis presents a research-based project that captures and evaluates the PBS experience of nurses in an NHS mental health organisation that provides care for individuals with learning disabilities and/or mental health issues. In writing it, I have made an informed decision to use the first person because in doing so I feel freer to engage with the narratives and general discussion. It is my view that the first person allows me to, succinctly, describe my actions and approach at every step of this study.

The chapters are set out as follows:

Chapter 3 provides an up to date literature review on PBS. It explores the evidence base on the subject, identifies gaps and further informs my approach. Chapter 4 sets out my ontological and epistemological position. This section provides a detailed explanation of the selection process undertaken to identify the most appropriate methodology, methods, and process for this research. In it, I present the characteristics of the participants and my reflexive approach to the study. It includes the ethical background and professional considerations that bear influence throughout the project, together with data collection results and analysis of them. The analysis and findings are discussed in Chapter 5, where I present the themes that emerged, and go on to demonstrate how they became themes, along with relevant explanations and descriptions. Chapter 6 discusses these findings and their correlation to current evidence on PBS. The conclusion and recommendations form Chapter 7 where I offer and explain my views and ideas for the advancement of PBS in mental health organisations and propose future research in relation to the findings of this study.

2.2.1 Motivation for this study

My experience of working in a mental health organisation posits that patients who display behaviours of concern, such as violence and aggression, tend to remain in-patients for a longer period. As a nursing professional, I have always worked tirelessly to support discharge of patients into their community, so they are able to live closer to their family and friends while receiving proper support. But my drive and duty as a clinician is not only to support a timely and appropriate patient discharge into the community with a well-designed care package, but also, while it is necessary for these patients to remain in a ward environment, to ensure they are given the required support for full recovery in an environment that is safe, therapeutic, and as unrestrictive as possible. However, mental health service figures suggest concerning levels of violence against patients and staff (Estryn-Behar *et al.*, 2008; Tolli *et al.*, 2017). Some of these incidents partly originate from a lack of appropriate support, evidence-based practice, poor care or treatment failures (McKeown *et al.*, 2019). Substance misuse, social influences and environmental factors compound this problem, thereby creating a situation of acuity in mental health services so that reactive approaches from staff are thought to be catalysts for further restrictive interventions (Power *et al.*, 2020). Challenging behaviour is commonly the reason for using restrictive interventions likely to compromise the dignity and human rights of service users and also traumatise them (DH, 2014). My overarching aim as a consultant nurse is, therefore, to support services and patients by providing therapeutic and evidence-based interventions that are least restrictive and recovery focused. My approach tends to contribute towards suitable patient discharge into supportive community placements. Nonetheless, a national outcry prevails over under-resourced mental health services and the need for further investment (United Nations, 2020; Rosen *et al.*, 2020). My professional experience so far postulates that mental health services need skilled, competent staff who have the professional attitude and are properly supported to achieve their best in a challenging environment.

Mellow *et al.* (2018) claim that behaviours that challenge affect stakeholders at various levels, primarily impacting patients, their family members, carers, and professionals. In my previous capacity as ward manager, I was introduced to PBS as an intervention helping to support individuals with complex needs and ward colleagues expressed interest in becoming more aware of the framework. This awareness was achieved through training provided by the British Institute of Learning Disabilities (BILD). Serious adverse incidents at Winterbourne View in 2011 (https://www.bbc.co.uk › uk-england-bristol-20078999) brought PBS to the forefront of discourses initiated about PBS in practice (DH, 2014). The

Winterbourne View report depicted patient abuse at a criminal level and resulted in carers being imprisoned for their actions and omissions. However, 10 years after Winterbourne View, the Whorlton Hall investigation revealed far-reaching implications. Whorlton Hall was an NHS funded hospital in County Durham, UK, where patients with learning disabilities and autism were abused to the extent of torture, and endured extreme psychological distress (Triggle, 2019). Such heinous examples demonstrate the impact of oppressive social constructions in terms of long-term consequences for patients.

2.3 Background

Gore *et al.* (2013) describe PBS as a multicomponent approach that focuses on reducing behaviours that challenge while applying behavioural techniques to improve quality of life (QoL). It is documented that service users who are perceived to exhibit behaviours that challenge are more at risk of abuse themselves, as a result of various restrictive interventions (Royal College of Nursing, 2017b). In the UK, multiple inquiries, such as Winterbourne View (DHSC, 2014) and the Commission for Healthcare Audit and Inspection (2006, 2007), have evaluated the care of people with challenging behaviour and made recommendations relating to cases of exposed abuse, neglect and criminal behaviour against service users. Moreover, it was found that the process of commissioning services for people with challenging behaviours is a complex one, necessitating fundamental changes to achieve improved care. The report 'Stopping Over-Medication of People with Learning Disabilities' (STOMP), (NHS England, 2016) identifies an overreliance on medications in cases of challenging behaviour, which has become a perpetuating practice (Tsiouris, 2010; Flood, 2018). The STOMP report and the National Institute for Clinical Excellence (NICE, 2015) favour non-pharmacological/behavioural interventions, and PBS is being proposed as one such approach (NHS England, 2016). This is corroborated by Gerrard *et al*. (2019) who indicate that PBS, if implemented successfully, may help reduce the use of medications in some clinical areas. Nevertheless, although the prescription and administration of anti-psychotic medications are based on clinical judgement, this is often grounded in a combination of other factors; one being the dominance/dependence on a biomedical model of care, but also in a lack of in-depth behavioural understanding or a lack of alternative treatment options.

A perceived need to apply restrictive interventions could emanate from biomedical models of care in which mental illness is conceptualised by the reduction of symptoms, or reinstating functions though pharmacological interventions (Deacon, 2013). Indeed, the Critical Psychiatry Network (www.criticalpsychiatry.co.uk), founded in the UK, questions

the dominance of the biomedical perspective. It revolves around the neo-Meyerian approach that emphasises the importance of social, personal, political and cultural influences for understanding mental illness (Farre and Rapley, 2017; Bhui, 2019). Advocating a biomedical approach to mental health has meant interventions such as physical restraint, seclusion and over-reliance on medications have evolved into common practices. In the absence of suitable alternatives, these practices have attracted substantial scrutiny due to the harm they cause to both service users and staff (Kelly *et al.*, 2016; Power *et al.*, 2020). It is within this context that PBS emerges as an intervention that might offer opportunities for a cultural shift to a situation where psychological, holistic, and strength-based approaches to mental health receive equal standing in the care delivery process, alongside equal recognition of important biomedical approaches. In this way, PBS seems to offer professionals and service users a tool for understanding the functions of behaviours, and thereby potentially reduce the use of restrictive interventions. As such, it constitutes a further argument for examining the integration of PBS in mental health services.

2.4 Restrictive interventions and practices in context

The terms 'restrictive interventions' and 'restrictive practices' are frequently used interchangeably in literature (Connolly *et al.*, 2019). However, there is a clear distinction between these terms. Restrictive interventions are deliberate acts that restrict an individual's movement, liberty, or freedom to act independently (MHA CoP, 2015). Its application takes control of a dangerous situation that could otherwise cause harm (DH, 2015). Restrictive interventions include seclusion, physical restraint, long-term segregation, enhanced observations, and rapid tranquillisation medications (MHA CoP, 2015; NHS Protect, 2017). By contrast, the DH (2014, p.9) defines restrictive practices as: 'making someone do something they don't want to do or stopping someone doing something they want to do'. In a mental health and learning disability context, restrictive practices may include locked wards, or limited access to internal and external facilities. Additionally, the DH (2014) describes a restrictive practice as action that limits or confines the movement of individuals, hence reducing someone's liberty and freedom.

Most interventions, while carrying different levels of risks, are applied to suppress potential or actual situations of violence and aggression (Cowman *et al.*, 2017), although enhanced observations also serve limited benefits in circumstances that risk self-harm (Reen *et al.*, 2020). Enhanced observation, when inappropriately used, can be just as restrictive and traumatic for service users while not necessarily offering therapeutic effects (Reen *et al.*, 2020). Unfortunately, in some cases, staff use high levels of restrictive

interventions without appropriate clinical justifications, which may compromise patients' human rights (Kinner *et al.*, 2017).

Many incidents of abuse and neglect have come to light in the absence of sustainable, evidence-based, and long-term supportive interventions including PBS. Some of these cases can be read in the Winterbourne View and Whorlton Hall reports where the most horrific, humiliating, and unlawful practices are recorded (Taylor *et al.*, 2017; Triggle, 2019) (see 2.2.1). These two scandals depict the poorest care standards and treatment failures in the absence of leadership, accountability, and lack of evidence-based behavioural approach to care.

It is well-documented in local and national policies that restrictive interventions should only be used as a last resort in safeguarding patients' best interests (DH, 2014). But the specified concept of 'last resort' is not fully defined or understood amongst mental health nurses (RMNs). Riahi *et al.* (2020, p 1225) highlight a few particulars in determining 'last resort' which include 'individual, interpersonal, historical and situational' aspects. However, Kelly (2016) and Power *et al.* (2020) describe 'last resort' as a high-risk situation in which no other interventions have produced a positive outcome. A restrictive intervention is inevitable from this perspective, particularly when a prompt intervention (such as physical restraint) is required to save life and if there is no response to verbal de-escalation, and it should be applied in the best interest of the individual. In such a scenario, physical restraint should be values-based, outcome-focussed, dignified, and respectful to the individual receiving the intervention; it should only be used when absolutely necessary, using approved physical techniques (DH, 2015), and by experienced staff who have the required skills, training and competence. If inappropriately administered, restrictive interventions in the form of physical restraint may lead to serious physical and psychological harm or injuries (Cusack *et al.*, 2018). Patients have died during physical restraints and in other cases they have been left extremely traumatised by the experience. In the context of avoiding such trauma, PBS is being presented as a framework that facilitates the least restrictive process of care. The framework is described as an approach holding the preservation of human rights as one of its main philosophical principles.

In 2014, the UK Department of Health published 'Positive and Proactive Care: Reducing the Need for Restrictive Interventions'. This document was partly in response to the Winterbourne View incident, and partly to the MIND report 'Mental Health Crisis Care: Physical Restraint in Crisis', which was published the previous year (2013). One finding from the MIND report relates to an alarming increase in the number of restraint incidents,

often being used as a first line of action. The same report shows a wide variation of physical restraints across several mental health services in England. For example, among 51 NHS trusts responding to a survey, one trust recorded 38 incidents in a single year while another reported 3000 incidents in the same year.

Subsequent to the above discourse and detailed explanation of the different terms, also underpinned by DH (2014), I will use the phrase 'restrictive intervention' to refer to interventions such as physical restraint, pharmacological restraint, use of rapid tranquilisation and seclusion.

2.5. Positive Behaviour Support

2.5.1 The framework – distinction between PBS and ABA

PBS originates from Applied Behavioural Analysis (ABA) and is grounded on a functional assessment and a functional analysis; two distinct features that are often misunderstood (Tincani, 2007; Dunlap *et al.,* 2008; Smith and Nethell, 2014). Functional assessment is commonly referred to as a process of gathering vital information about an individual which then develops into a hypothesis. There are various ways of conducting a functional assessment, but most methods would incorporate a functional analysis, a robust and methodical process whereby various hypotheses are tested and verified. This process involves identifying antecedents, behaviour, and consequences (ABC) to establish their effects on behaviour. Correspondingly, there is a lack of clarity as to whether there is indeed any contrast in principle or application between PBS and ABA. Authors such as Johnston *et al*. (2006), Foxx (2005) and Mulick and Butter (2005) view PBS as a paternalistic approach, and they hold a dissenting view on the effectiveness of PBS when applied to challenging behaviour. The same authors describe a tension between ABA and PBS that is reinforced by discussion around the scientific merit of PBS (Hayward *et al.*, 2021). Further, PBS is described as labour intensive and requires significant resources to showcase any difference in practice (Hassiotis *et al.*, 2018). It is argued that a functional assessment is not what distinguishes PBS from ABA; the difference is more about the aversive and non-aversive interventions within the frameworks (Hassiotis *et al.*, 2018). Baker and Allen (2012) have identified PBS as an evidence-based practice and distinct from ABA. They recognised PBS as a concept derived from the human rights ethics that value every person's individuality, whereas they consider ABA limited as an intervention because it makes an individual approach inflexible (Baker and Allen, 2012; Kincaid *et al.,* 2015). According to Singer and Wang (2009), a preference towards the PBS framework is due to its focus on dignity and

respect, which provides a structured approach to active patient participation. Another key element of PBS is its person-centred approach towards situations of challenging behaviour (Gore *et al.,* 2013), thus making it a framework of choice compared to intervention such as ABA, which is described as punitive (Weiss and Knoster, 2008; Grey *et al.,* 2016). While the focus of ABA is on the individual's behaviour, PBS approach is to understand the reasons for a particular behaviour to take place.

Baker and Allen (2012) engage stakeholders in exploring the evidence-based aspect of PBS. The authors make a clear distinction between PBS and ABA while arguing that this separation is extremely important for the future practice and validity of PBS (Baker and Allen, 2012). Despite a distinction between PBS and ABA, there are debates on the validity of PBS (Tincani, 2007; Reid, 2020). This discourse is grounded on the argument that, although PBS is depicted as a new science, it remains a derivative of ABA (Reid, 2015). Additionally, there is a critical viewpoint that questions the validity of PBS as a science (Wacker and Berg, 2002; Kincaid, 2018). Despite its scientific underpinning, some protagonists fear PBS could create confusion and ambiguity, mainly because the practice is largely a by-product of ABA. Indeed, PBS and ABA display common core features in their forms of assessment and data collection (Gore *et al.,* 2013). Possibly due to these similarities within their basic elements, PBS and ABA are often used interchangeably in certain platforms as argued by Carr and Sidener (2002). However, the emergence of PBS is said to be partly grounded on the use of non-aversive techniques, favoured because they are not punitive, bearing only potentially therapeutic consequences when applied (Dunlap and Carr, 2007). This argument seems to highlight a departure from ABA that has brought PBS to the fore as a non-aversive intervention.

2.5.1.1 The development of PBS as a framework

So, PBS, as claimed by Smith and Nethell (2014), has gained impetus as a framework with theoretical foundations supporting the values of human rights, and it offers an expansive and sophisticated practice that requires an MDT approach, by contrast to ABA. Furthermore, it is argued that targeted training is not required during PBS implementation, but is required with ABA (Tincani, 2007). This raises the issue that clarity is needed regarding any credentials that should be required before delivering PBS in practice (Reid, 2020). Based on these claims, some researchers are concerned that PBS could continue to be confused with ABA (Mulick and Butter, 2005; Kincaid, 2018).

According to LaVigna and Wills (2012), PBS is a non-aversive care framework that is, proactive, values-led, and grounded in a multi-element structure that improves individuals'

quality of life. The Department of Health (DH, 2014) finds PBS useful in areas of challenging behaviour and suggests that the practice may improve the care of our in-patients in mental health services. The PBS framework provides sets of evidence-based interventions consisting of proactive measures to support service users with complex needs who display behaviours of concern (Padden, 2016). However, there is no allusion that the mere presence of PBS plans would address behaviours that challenge. The PBS framework, as any other evidence-based intervention, is firmly centred on the skills and competence of practitioners and service users engaging with the intervention. PBS is composed of primary strategies (actions that prevent the occurrence of certain presentations), secondary strategies (verbal de-escalation), and reactive strategies ('as a last resort' and may involve the use of medications or physical restraints). Correspondingly, while PBS aims to improve individual quality of care, it does not exclude the use of physical restraint or medications as a last recourse. This implies that PBS may not be the one framework to help resolve challenging situations and raises queries around its reliability and consistency. For instance, in some clinical areas where high levels of extreme violence combine with an immediate danger to life, there may be an argument for using physical restraint to manage disturbing behaviours. This could be interpreted as somehow showing a failure of the implementation of PBS and its principles of least restrictive intervention. Physical restraint may be justifiable and necessary to safeguard service users' interests. The reference to interventions of last resort suggests PBS on its own may not suffice. Trained staff, patient engagement, leadership, an environment that helps recovery and supports family and friends, are further contributory factors. PBS's primary strategies emphasise meeting individual needs; the proactive approach is to minimise behaviours of concern, while the reactive aspect of the framework (http://pbsacademy.org.uk/wp-content/uploads/2016/11/Positive-Behavioural-Support-Competence-Framework-May-2015.pdf) offers a process of addressing challenging behaviour when it occurs. It is therefore proposed that the focus of PBS is on understanding the function of a behaviour and the triggers associated with it. PBS delivers a process to help address these triggers and so meet individual needs. In practice, PBS starts with a functional assessment, the collection and evaluation of information that informs the person's behaviour, before developing a PBS plan to actively support that person (NHSE LGA, 2014). Conversely, some authors have criticised PBS as being too reliant on a functional assessment (Crone and Horner, 2003; Koegel *et al.*, 1996; Lucyshyn *et al.*, 2002).

2.5.1.2 The values of PBS

An initial attempt to define PBS was made by Horner in the 1990s (Horner *et al.*, 1990; Crone *et al*., 2015), describing it as a non-aversive behaviour management framework. This primary definition comprised characteristics of functional assessment, lifestyle changes, and minimising the application of non-aversive techniques, but omitted to focus on its person-centred approach.

Gore *et al*. (2013) streamlined the key features of PBS for added clarity, so offering a guide for the development of PBS policies and future research initiatives. The main elements within the Gore *et al*. (2013) definition are:

- Values
- Theoretical underpinnings
- Process

It is suggested, by Gore *et al.* (2013), that the values component of PBS, if correctly used, should focus on the dignity and respect of individuals at all stages of their care. It emphasises improved quality of life. However, 'dignity and respect' may be perceived subjectively by different practitioners, according to their own life experiences, who therefore bring different perspectives to the meaning of 'quality of life'. Existing evidence on the effectiveness of PBS offers clinicians and patients a structured approach to good practice that is informed by data (BILD, 2015). PBS is thought to present sets of interventions that capture patients' choices, respect, and dignity. In the same vein, Davies *et al*. (2016) present PBS as a multi-component framework approach that favours safe and therapeutic intervention. It should usefully be noted that this aspect of PBS is not a new concept in mental health practice. The Human Rights Act (1998) makes provision for individuals not to be subject to abuse or be victims of degrading or inappropriate treatment.

Hassiotis *et al.* (2018) claim that PBS is already widely practised in specialist schools, but it is only gradually being recognised in health care environments. As the practice expands into patient care it is being recognised as an effective and reliable intervention particularly in mental health services (Griffiths and Wilcox, 2013).

In 2015, the BILD, in partnership with other organisations and individuals who promote the practice developed a PBS competency framework (http://pbsacademy.org.uk/wp-content/uploads/2016/11/Positive-Behavioural-Support-Competence-Framework-May-2015.pdf), which sets out essential elements that stakeholders 'need to know' and 'need to do' about PBS implementation.

Ham and Davies (2018) argue that patients' involvement is a key feature that ensures the effectiveness of PBS. Engagement from service users, being experts by experience, brings context to the framework's application. Their involvement means all voices are heard and creates a shift from a professional-driven focus to stakeholder participation. Patient involvement underpins notions of co-production, sustainability of the intervention, and patients find a voice where their lived experience is valued. Carr *et al.* (2002) argue that PBS proposes an egalitarian approach to care. However, service users' engagement is not a new notion or unique to PBS. Indeed, the Mental Capacity Act (2005) makes it a legal duty for services to engage service users in their care. Correspondingly, there do exist various barriers to service user participation that PBS does not necessarily address. Challenges may include language or other communication barriers, lack of support, or a perceived dominance of the biomedical model of care. The adoption of a collective and multi-pronged approach may identify challenges and establish opportunities for service users to engage in their recovery while influencing the overall organisational and clinical decision-making process. Co-production as a concept and practice remains a contested field of complex power dynamics contingent upon constructions of mental ill health, the positionality of service users and the question of the legitimacy of voice and experience in the relationship between power and knowledge.

In a review of various studies, LaVigna and Willis (2012) describe PBS as a valuable concept that is worth implementing and as a cost-effective framework used predominantly in learning disability sectors but progressing into mental health settings to address behaviours of concern. A fundamental attribute of PBS that has been illustrated here is its focus on individuality and human rights, even though safeguarding the human rights of service users is already well established in law, and grounded in the moral, ethical, and professional duties of staff. It is therefore argued here that the human rights component of PBS is not unique. Iwata *et al.* (2000) explain that PBS is effective when careful assessment and analysis of individuals' functional abilities is carried out in conjunction with a thorough history-taking process that explains an individual's behaviour. Paley-Wakefield (2011) supports the use of PBS in challenging environments, especially when implemented systematically. Furthermore, Davies *et al.* (2015) suggest that service users' involvement and engagement in PBS delivery is of great significance in its effective practice (Davies *et al.*, 2015).

In LaVigna and Willis (2012), the need for specialised accomplishments or expertise to complete a functional assessment is unclear, despite this aspect remaining a critical feature of PBS that would inform non-aversive interventions. On his part, McGrath (2013) explored

carers' influence in the assessment process and has accordingly proposed a correlation between assessment and expertise. Her argument is reinforced by Allday *et al*. (2011) who underline the significance of carers' contribution and experience when collecting data during a functional assessment. These authors seem to suggest that such level of engagement from carers ensures the effectiveness and a high level of co-production in practice. It appears that current literature places insufficient emphasis on PBS being a multi-pronged approach that requires the input of carers and professionals from a range of expertise. OTs, nurses, clinical psychologists, and medical staff are all among the valuable players in PBS. However, LaVigna and Willis (2012) omit discussion of these varied skills and challenges that are needed in order to embed a multidisciplinary approach in PBS. Moreover, if PBS is to be led by different stakeholders, any dispute must be addressed about the expert input required to ensure those all-important 'experts by experience' and those people with lived experience are empowered to make their vital contributions.

Particularly in complex and challenging environments, effective teamwork is fundamental to successful outcomes because it ensures a coordinated approach to care. It is, however, a crucial prerequisite of PBS that appeared lacking in my reading and experience of the framework where poor team cohesion has the effect of compromising delivery.

Griffiths and Wilcox (2013) studied PBS application in a medium secure psychiatric unit where they observe it to be insufficient on its own. They claim strong leadership, effective communication and staff training as some of the preconditions for the successful application of PBS. The study by Griffiths and Wilcox (2013) proposes that the efficacy of PBS in a mental health unit was dependent on a consistent approach and reveals noteworthy evidence around the development of positive and meaningful relationships between staff and service users, leading to a reduction in behaviours of concern. In support of this, PBS has provided staff with vital knowledge, skills, and awareness of how environmental and other factors influence challenging situations. Griffiths and Wilcox (2013) found that, after employing PBS for 2 years, the needs of service users were successfully met, showing reduction in incidents of challenging behaviours. On the mental health ward where PBS was practised, a substantial decline in aggression and violence levels was observed, together with a corresponding increase in behaviour that was considered meaningful, positive, and adaptive. It remained unclear how staff skills and competence were addressed, and what specific factors influenced relationships between service users and staff.

Nevertheless, emerging evidence confirms PBS as an extensively exercised values-based framework with positive potential to improve quality of lives (LaVigna *et al.*, 2012;

LaVigna *et al.,* 2005; Hanley *et al.,* 2003; Hassiotis *et al.,* 2014; Strydom *et al.,* 2020). Its person-focussed and individualised features make PBS a much-preferred framework compared to other practices (Weiss and Knoster, 2008; Hassiotis *et al.,* 2014). What is more, a few studies have validated PBS as scientific practice in the management of behaviours that challenge (LaVigna and Willis, 2012; Gore *et al.,* 2013; MacDonald and McGill, 2013; McClean and Grey, 2016). Evaluations of PBS are further explored in my literature review (Chapter 3) that includes current discourses.

Literature proposes PBS as a useful tool that helps identify the causes of behaviours that challenge (Chiu, 2012; Hassiotis *et al.,* 2014). Same literature proposes that PBS espouses the Deprivation of Liberty Safeguards (DHSC, 2018b) and principles of the Human Rights Act (1998) in such a way that it promotes practices that are safe and least restrictive. Therefore, it is argued by Paterson and Bradley (2009) and Lord Carlile of Berriew (2006) that PBS offers some contribution towards an organisational impetus to reduce restrictive interventions that too often result in physical and psychological injuries, trauma, and death (The Care Quality Commission (CQC), a UK health regulatory body, have reviewed their inspection approaches and renewed their resolve to hold services to account through robust scrutiny. In areas of challenging behaviours, the CQC has recommended that PBS be considered and used as appropriate (CQC, 2017), and could take the form of a risk assessment and care planning process for individuals who disproportionately challenge services (CQC, 2017). However, the CQC attracted serious criticisms on its handling of Winterbourne View, where they failed to intervene to stop patients abuse, leading to a public expectation that CQC becomes more transparent and fit for purpose in order to gain public confidence and for their recommendations to attract respect and wider implementation.

In the area of staff awareness, training is considered essential for building confidence and competence to successfully implement the PBS framework and bring about health improvements (Walsh *et al.,* 2018; Bowring *et al.,* 2020). In the context of challenging behaviour, staff confidence and experience of using the PBS framework are prerequisites to consistently and ethically supporting people with complex needs.

Ham and Davies (2018) support the idea of a co-produced PBS practice that stimulates positive and long-lasting changes in patients' care. This endorses the view that its effectiveness is partly conditional on service users' engagement with the framework, and opportunities to work alongside PBS facilitators. Aspiration is for service users to take ownership of PBS and be actively involved in its development in a way that would inform their care pathways and enhance the meaning of individualised and person-centred care.

Certain organisational and professional barriers that hinder this realisation; ones that mental health organisations need to acknowledge and address.

2.5.1.3 School settings

From a historical perspective, as previously mentioned, PBS started in specialist schools. Luiselli *et al*. (2010) made a study about school students being the recipients of PBS due to varying degrees of behavioural concerns. Some behaviours were described as acts of vandalism, bullying, intimidation, threatening behaviours, and others were acts of violence and aggression. The aim of PBS in this context was primarily to improve the children's conduct and to provide them with opportunities for academic accomplishment. PBS was also used with an aim of improving school safety and creating an environment conducive to learning, growth and personal development. Luiselli *et al*. (2010) assessed a baseline, then compared it to the period after PBS was implemented (a pre and post-test). The outcomes showed a substantial upturn in the children's behaviour, coupled with improvement in their academic success. It was observed that children who would otherwise display disruptive or violent behaviour were calm and acted responsibly towards others. Another positive outcome was the significant reduction in-school suspensions and other corrective measures. However, although remarkable improvement was noted in certain areas, the study did not clarify whether expert input or special training was indeed essential for the effective implementation of PBS. Besides these optimistic deductions, a good understanding of individual, social, family, and environmental issues are all significant and equally relevant determinants that may influence pupil behaviours. The involvement of teaching staff in this PBS project was indispensable to ensure the framework was aligned to academic accomplishment, although a later study (Oliver *et al.*, 2019) reported teachers as finding PBS difficult to engage with.

McCurdy *et al*. (2003) is yet another example that illustrates the use of PBS in a school milieu with concerning levels of disruptive behaviour. In that school, PBS was offered in a non-classroom environment (i.e. playgrounds) where antisocial behaviour was intense. PBS facilitators were supported by teachers and other professionals in the delivery of the framework. After a period of implementation, punitive measures against students were reported to have decreased because of a decline in the number of assaults by the students. Putnam *et al*. (2003) repeated a similar intervention, but this time addressed inappropriate behaviour on school buses. Both Putnam *et al*. (2003) and Luiselli *et al*. (2010) are good evidence that illustrates the successful application of PBS in school-related situations, but neither explores past trauma, social, individual, or political issues that may have impacted the schoolchildren's behaviour. Family context is another major consideration when evaluating

children's behaviour at school, and omission of the context or situated knowledge and experience of these young people results in a divisory practice of separating the context from pathology, which results in the construction of individuals as pathological rather than the context as a reproducer of pathology.

A wide range of discourses are seen to advocate the use of PBS in school settings where challenging behaviours and lack of discipline prevail (Schall, 2010). A body of evidence also shows positive outcomes for students' educational accomplishment, through improved social behaviour, because of the successful implementation of PBS (Algozzine and Algozzine, 2009). Due to this, PBS is proposed as a useful tool that can enhance the delivery of educational programmes by suggesting environmental changes (Luiselli *et al.,* 2010; Algozzine and Algozzine, 2009). Cage *et al.* (2015) make a similar claim about PBS being an iterative process that can support teachers and schools in delivering academic programmes. However, it should be argued that the efficacy of PBS in a school environment is subject to several factors (Handler *et al.,* 2007), to include a team of properly trained staff, staff engagement with the PBS process, and the passion to work with children with challenging behaviour (Iemmi *et al.,* 2016). PBS requires a multitude of interventions to be successful.

2.5.1.4 Training

Evidence suggests that PBS training has a positive causal effect on staff's emotional response, knowledge, and attributions about challenging behaviour (MacDonald and McGill, 2013). Training shows a significant margin of success in the care delivered by trained as opposed to untrained staff, although it is clearly desirable for training to be specific and relevant to the service (Hassiotis *et al.,* 2014). A learning disability service within a mental health organisation, for example, would require PBS training that equips staff to work with this client group who may often have underlying mental and physical health issues. A functional behavioural assessment within the process of PBS is aimed, among other things, at capturing an individual's coping strategies and, through that, the best route by which to address particular behaviours. This is an elementary stage of PBS, and it is advised that staff are given specific training to undertake a functional assessment (Dunlap and Kern, 2018).

PBS training and practice receives mixed reviews. Hassiotis *et al*. (2018) found no identifiable changes in intervention following training compared to treatment as usual. Nonetheless, the quality of training is an essential outcome measure. Davies *et al.* (2019) indicate a significant reduction in aggression after well-delivered PBS training in a mental health service. Klaver *et al.* (2020) support some findings of Davies *et al.* (2019) relating to behaviours that challenge. Improvements were, however, evident in quality of life data

following PBS training. Effective training was found beneficial in reducing the instances of physical restraint, which had been commonly used restrictive interventions in a learning disability service. On the other hand, Strydom *et al.* (2020) found few clinical or cost-effective benefits of PBS training in the care of individuals with ASD. Although variances emerge regarding the efficacy of PBS training, the usefulness of PBS itself is not disputed, which renders it widely accepted as an iterative framework.

2.5.2 PBS and quality of life (QoL)

Gore *et al*. (2013) and MacDonald *et al.* (2018) include quality of life (QoL) as an important outcome measure of PBS practice. Studies have found that PBS improves and enhances the QoL of individuals (LaVigna and Wills, 2012; Wardale *et al.,* 2014; Hassiotis *et al.,* 2018). In the field of learning disability, Felce and Emmerson (2000) suggest an 'eight core domains' model enabling assessment of QoL. These domains, supported by Schalock (2000), comprise emotional well-being, material well-being, personal development, physical well-being, self-determination, social inclusion, and rights. However, in a systematic review of QoL for people with learning disability who present with behaviours that challenge, Townsend-White *et al.* (2012) found no instruments that exclusively and appropriately measured or assessed this population group's QoL. Despite the argument that successful PBS improves the QoL of service users with a learning disability, there seems to be a lack of evidence on the impact of the framework on the QoL of the mentally unwell population group. One reason is the slow acceptance and application of PBS in mental health settings.

Cummins (2001) is of the view that QoL is predominantly measured from a professional rather than from a service user's perspective, thus implying that it depicts professional concerns about people with learning disabilities rather than those expressed by individuals from the population group. Given this discourse, the influence of PBS on QoL may not be appropriately measured, leading to the premise that any measured characteristics of QoL should use the service users' frame of reference as a starting point.

2.5.2.1 QoL and consistency in care

Nevertheless, Walsh *et al.* (2018) explored the impact of PBS staff training on the QoL of forty-nine service users with learning disabilities, living in supported accommodations. The findings indicate an improvement in QoL through environmental changes in the service where staff had PBS training compared to where there was none. The outcomes were measured using the World Health Organisation QoL domains, focussing on physical and psychological health, social relationships, and immediate environment. In this situation, PBS training was shown to be effective in improving the environmental aspect of the setting,

thereby enhancing QoL from that viewpoint, which further indicates that their environment significantly affected service users' experience. What remains unclear is whether it referred to the physical, social environment or therapeutic climate of the setting. LaVigna and Willis (2012) report on PBS and its correlation with QoL but supply no supplementary details of precise ways by which the quality of life was measured from a service user's perspective. By contrast, Webber *et al.* (2017) present a case study of someone with learning disability whose QoL improved following implemented PBS care plans aimed at reducing self-harm and mechanical restraint. The study shows that a collective approach underpinned by PBS helped in situations of self-harm, and that the need for physical restraint was subsequently reduced, thus improving their subjects' QoL. Despite these findings the use of reasonable force to save a life may be deemed necessary in some cases (Ye *et al.*, 2019), although the use of aversive interventions may depict a treatment breakdown or failure to use PBS correctly. In Webber *et al.* (2017), consistency of care was considered an integral element towards the reduction of self-harm incidents leading to improved QoL. However, little context is provided to illustrate how teamwork influenced the delivery of PBS that changed the subject's self-harm presentation. It would be of significant benefit to PBS stakeholders to understand how the findings of this single case study might be transferrable to other self-harm situations. Nor is it clear whether other interventions, such as DBT which is accepted as reducing self-harm and suicide, were explored and, if so, to what effect (McCauley *et al.*, 2018). It may be contended that the central issues surrounding inconsistency and lack of teamwork needed addressing directly, rather than solely the choice of treatment.

The Royal College of Psychiatrists (2007) discussed the importance of a unified care approach towards behaviours that challenge, clearly highlighting the association between PBS and teamwork. It also accentuates the vital significance of the quality of therapeutic relationship between staff and service users. It is argued that successful therapeutic relationships provide safety, collaboration, and empowerment (Procter *et al.*, 2017). In Webber *et al.* (2017) an MDT approach to PBS, where OTs and Speech and language therapists were involved in supporting the process, was found useful. However, the study does not describe whether QoL was measured from a service user's experience or from a professional viewpoint. The study seems to conclude that PBS helped the individual to communicate their needs more successfully, thereby positively impacting on his self-harm behaviour. It is not reported whether other aspects of his life improved.

2.5.2.2 QoL and healthcare

Hodder *et al.* (2020) find a service delivery model grounded in PBS principles to be effective at improving the QoL of young service users, resulting in them developing their skills and reducing residential placements or CAMHS referrals. Similarly, Lee *et al.* (2019) refer to the improved QoL of a person with a learning disability and behaviours that challenge, whose antipsychotic medication was able to be reduced following a systematically implemented PBS plan. In this case, QoL was linked to reduced reliance on medications which may imply that his challenging behaviour may have signalled unmet needs rather than mental illness requiring medications. The introduction of the PBS model would seem to have helped identify these needs, allowing practitioners to better understand the function of this person's behaviour. However, one of the most significant accounts of the quality of lives in the field of learning disabilities was postulated by Niven *et al.* (2020). This review looked at the care of this cohort within the community following the closure of inpatients services. The study reports on individuals with complex needs who have lived through service breakdown and who had lived in institutions for years before being transferred into the community. They were enabled to live safely and with a satisfactory quality of life in their local community thanks to the use of PBS. This success was bestowed on properly designed PBS plans that were described as person-centred. The service users' QoL was grounded in meaningful occupations, less restrictive environments, and appropriate medications for behaviours of concern. Smith-Bird *et al.* (2005) argue, additionally, that PBS can improve the QoL of their families as well as of the individual service user.

2.5.3 Current context

Heyvaert et al. (2010) present PBS as a useful practice in the fields of learning disability and mental health a population group that too often experiences abuse, degrading treatment, and are recipients of poor care (MIND, 2013). Therefore, in this context, PBS appears to offer a framework driven by non-aversive strategies and that facilitates a structured step by step approach to care. The CCQ, in its annual assessment of providers, has recorded 10% of learning disability and autism services as inadequate (CQC, 2019); figures that are not significantly different for mental health services. Good practice guidance and government policies continue to raise awareness of what constitute improper practices, and provide an impetus to reduce unnecessary, abusive, or risky restrictive interventions (RCP *et al.*, 2007; BILD, 2014; DH, 2014).

The PBS framework is proposed by the Mental Health Act, Code of Practice (CoP), and the DH as one intervention that may help decrease restrictive interventions and practices in

mental health services (DH, 2014). The proposition is echoed by the CQC who ask health care providers to put suitable structures in place for individuals with complex needs and behaviours of concern (CQC, 2016; Riding, 2016), and to consider PBS as a potential tool when delivering care.

Frey *et al.* (2008); Baker and Allen, (2012) and LaVigna and Willis (2012) rank amongst a growing number of studies that support the use of PBS in care settings. In a review of 423 cases in LaVigna and Willis (2012), PBS was found to be a cost-effective intervention possessing characteristics to positively affect challenging behaviour. McClean *et al*. (2007) found a 66 % reduction in the use of antipsychotic drugs following PBS, although the study does not record any changes to personal circumstances and whether they too contributed to the decrease in medication; some influencing factors could be of a social, psychological, legal or idiopathic nature. Goh and Bambara (2013) found PBS effective in an educational setting where the practice helped achieve adaptive behaviour and reduce problematic behaviour. McClean and Grey (2012) reported a 14 % decrease in behaviours perceived as challenging. Even more optimistically, Hassiotis *et al*. (2009) confirmed a 43% drop in behaviours that challenge following implementation of a care package informed by PBS.

2.6 Conclusion

This chapter has provided context to the application of PBS, which is primarily used in learning disability services, specialist schools but is gradually being seen to develop in mental health service settings. The link between PBS and QoL, and its correlation to reduced restrictive interventions in mental health and learning disability services, is established This section also provides evidence through a range of RCT that PBS is an effective intervention. Therefore, PBS as experienced by registered nurses in areas of challenging behaviour is a significant topic in the debate and discourse of positioning PBS within the wider mental health services.

3.0 Literature Review

3.1 Introduction to chapter

This chapter explores the comprehensive approach I undertook during a systematic literature review, which aims to robustly present existing evidence and, concurrently, to identify the gaps which led to the conceptualisation of this study. Many authors have analysed how best to undertake a literature review. Aveyard (2019) provides a clear, detailed step by step strategy and presents a robust practical guide of how to achieve one's goals. The broad concept of my study is to explore and understand nurses' experience of PBS, and this section explains the scoping process undertaken, using the initial research question, and the literature review that followed. The literature review furnished an understanding of the terrain around PBS, and this process helped to refine my research question. Each paper is identified through a systematic process alongside an individual critique.

3.2 Scoping process

Before developing my research question, I undertook a scoping exercise to assess and evaluate the extent of available and relevant literature. This was carried out through Google Scholar. Despite the currency of Google being debated (Boeker *et al.*, 2013), Google Scholar is described as the most extensively used search engine with a total of 67.3 % of all searches worldwide made through Google (Younger, 2010; Boeker *et al.*, 2013; Prins *et al.*, 2016). This scoping exercise revealed the depth and breadth of existing literature, and offered a sense of the variety, extent, and nature of present academic evidence on PBS, including nurses' experience.

3.3 Initial research question

Nusrat *et al.* (2016) and Aveyard (2019) suggest that the initial search question is used to guide the literature review in an iterative process, and this then leads to refinement of the question and identification of the process areas, and gaps that the research needs to address. I developed my initial research question using patient population (P), intervention or issue of interest (I), comparison intervention or issue of interest (C), and outcome(s) of interest (O) (PICO) (Cooke *et al.*, 2012; Aveyard, 2019) as follows:

P– Nurses

I– Positive Behaviour Support

C– No comparisons

O– Experience

The research question that I initially hoped to answer, based on the aims and objectives of my project, was: *'**What is the experience of registered nurses who use positive behaviour support?'*** Although this was modified to: ***'What are the experiences of clinical and educational staff who use PBS?*** as explained below.

3.4 Search method and strategy

An important step in my adopted search method was to categorise the type of literature that I wanted to focus on. For this purpose, and to best answer the research question, I made an informed decision to identify research literature or empirical research, and to identify studies that are qualitative, quantitative and with a mixed-methods approach. I also decided to exclude systematic reviews because I wanted to access primary sources rather than relying on a summary of the literature.

Although Aveyard (2019) encourages researchers to develop their hierarchy of evidence as informed by the specific research question, my view was to keep an open mind on this so as to fully appraise the extent of the literature. The next step was to establish the inclusion and exclusion criteria, decide on databases, search terms and the use of Boolean operators.

3.4.1 Inclusion and exclusion criteria

It was necessary to limit my literature search to materials published after the year 2000 because PBS was introduced in the UK in the 1990s, at which time it was predominantly used in special schools and children's services until 2000 (Horner and Sugai, 2018). In addition, PBS gained momentum following the advent of the DH policy 'Positive and Proactive Care: Reducing the Needs for Restrictive Practices', published in 2014. Nonetheless, PBS was widely mentioned as a preferred framework of care after the Winterbourne View incident (see 2.2; DH, 2014). Therefore, there may be evidence of PBS use in health services from 2000. Table 1 summarises the inclusion and exclusion I have set for this literature search, based on the research question.

Inclusion	**Exclusion**
Qualitative, quantitative, mixed methods studies	Systematic reviews
Research literature where methodology or literature review strategy is identified within the paper	Books
Peer-reviewed journals as they carry more recent evidence (Swainson, 2006; Hart, 2012)	Editorials, letters, book reviews, opinion papers or commentaries

Materials associated with the educational system e.g., specialist schools	Papers in press, conferences
English language papers with full title, abstracts and text that are either electronically available or hard copies could be ordered from a health trust or university library	Duplicate studies/ articles
Materials published from 2000 onwards	Materials that are not peer reviewed
Papers mentioning PBS in title, abstract or main body of paper in the journal subject areas of learning disabilities, mental health nursing, social care and healthcare.	

Table 1: Inclusion and exclusion criteria.

3.4.2 Databases

I used four databases for my literature search, namely: Cumulative Index of Nursing and Allied Health Literature (CINAHL), Medline, PsychInfo, and Psychnet-UK. This choice was based on which databases are considered essential when reviewing research that focuses on healthcare, social care, medical and nursing with an international scope (Wright *et al.*, 2015; Watson, 2020). Importantly, Flemming and Briggs (2007) and Watson (2020) reported on and supported the effectiveness of CINAHL, Medline, and PsycInfo when searching for evidence relating to individuals' experiences.

3.4.3 Search terms and Boolean operators

The terms selected for my literature search derived from my initial research question informed by PICO. The term 'Positive Behav* Support' was used as it ensured that terminologies such as 'positive behaviour support', 'positive behavioural support' and 'positive behavior support' (American spelling of *behavior*) were all covered.

I have used the principles of Boolean logic in the databases to facilitate a systematic search of the literature. I have used AND/OR commands while excluding the NOT command which may have excluded essential literature on PBS. I also made use of truncation, as and where appropriate, to ensure the search is robust and relevant papers are not missed out. For example, the word 'nurses' could be identified as 'nursing staff' or 'nurse'. To capture all these terms, I used the keyword 'nurs*'. While "Positive behav* support'' became a keyword in my search strategy I used ''double quotation marks'' so that the words are searched together.

During an initial systematic search, there was a poor outcome in terms of hits when I 'zoomed in' to explore nurses' experience of positive behaviour support. So, as suggested by literature and due to the lack of hits, I 'zoomed out' to consider the research question from a

broader angle. Aveyard (2019) uses the zoom in and out analogies to explain useful adjustments when faced with an apparent lack of literature, or too many research results, in a particular area or topic. After this, the refined research question became: ***'What are the experiences of clinical and educational staff who use PBS?***

I used the PICO guidance in a similar way to further develop my search terms as presented in Table B (below). This included nurses and a wide range of other stakeholders such as psychologists, occupational therapists, social workers, and teachers. By working in this manner, I maximised the probabilities of capturing the experience of various individuals involved in PBS through the literature search.

Finally, the following terms were used in the search strategy in conjunction with the Boolean operators: ''Positive Behav* Support'' AND views OR experience OR attitude OR perception OR nurs* OR nurses' experience OR school OR social workers OR mental health OR learning disabilit* OR intellectual disabilit* OR learning disorder OR learning difficult* OR psychology OR occupational therapy.

3.5 The search process

A systematic literature search was initiated in May 2017 with the terms described above, while applying my inclusion and exclusion criteria. The search was repeated in March 2018, May 2019, April 2020, April 2021, and again in December 2021 using identical keywords to ensure the material has remained up-to-date and current.

I reviewed the reference lists of all identified papers, as suggested by Hart (2018) and Aveyard (2019), to check for literature that I may have overlooked. The overall process is illustrated in the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flowchart (Figure 1) that summarises the outcome of the literature search. The PRISMA flow diagram was developed by Moher *et al.* (2009) and offers a cohesive and comprehensive account of methods undertaken during the literature search.

14 studies were identified through the literature search as detailed above. They are discussed below.

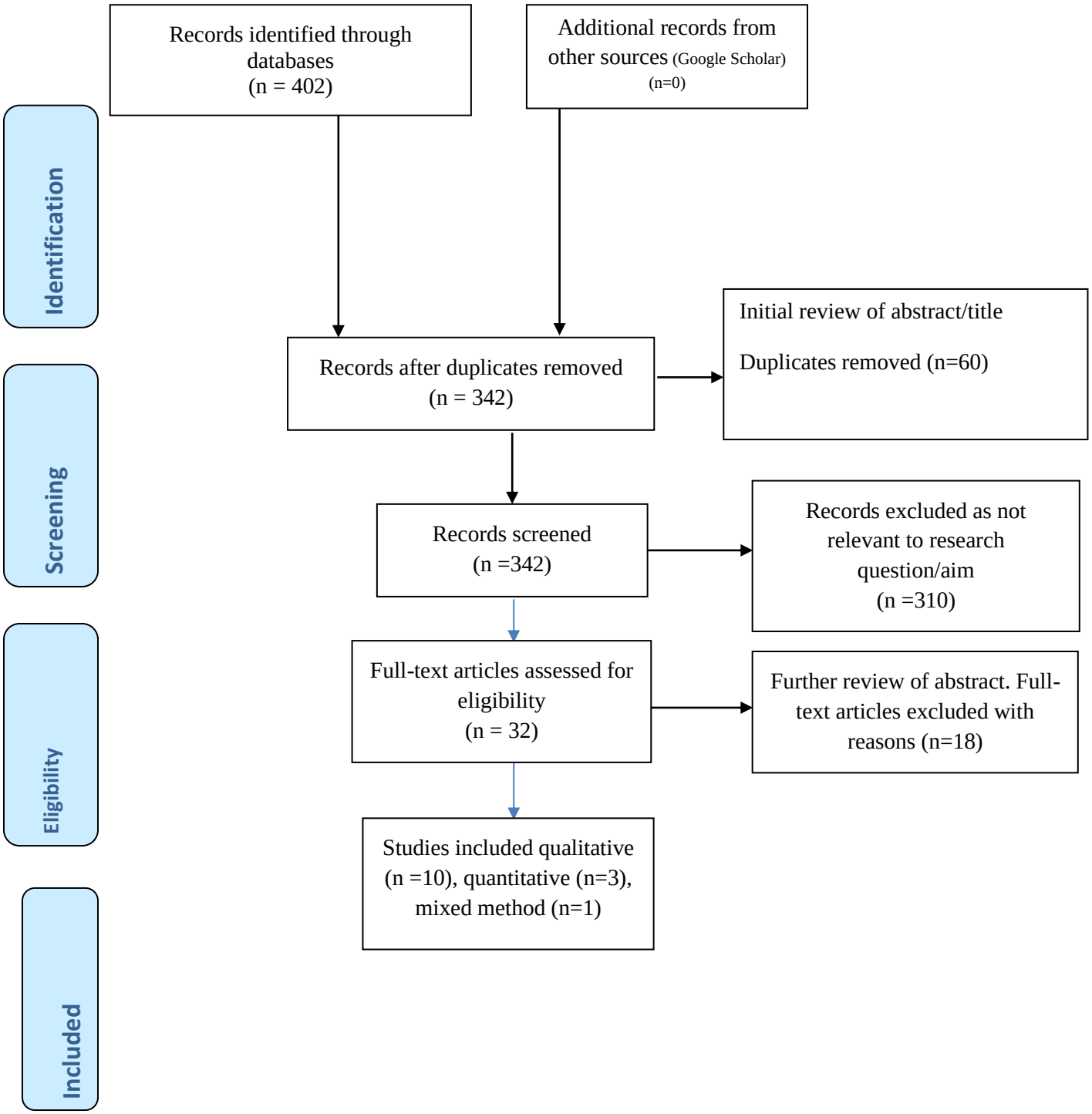

Fig. 1: PRISMA flowchart (Moher et al. 2009)

3.5.1 Quality of studies and critical appraisal tool

There are several appraisal tools available to assess the quality of literature, such as CASP, SURE and AMSTAR. I used the Critical Appraisal Skills Programme (CASP, 2018) and the mixed methods appraisal tool (MMAT) to review the credibility and validity of identified articles because they both provide useful criteria as a framework in the evaluation of research studies (Campbell *et al.*, 2011, CASP, 2018, Hong *et al.*, 2018). CASP has been

found useful and appropriate for the appraisal of qualitative and quantitative research studies because of its succinct approach (Downe *et al.*, 2007; Campbell *et al.*, 2011; Valderas *et al.*, 2012; CASP, 2018). The MMAT tool suited the mixed method study as identified in my literature review (Hong *et al.*, 2018).

Identified articles were scored for quality using these selected appraisal tools and the quality scores were independently checked for accuracy and consistency by my NHS trust research department as well as an external verifier. There was no significant disparity between my scores and the independent scores. Appendix 3 provides a list of the 14 articles, a summary of the critical appraisal that I undertook, the quality score, and an essential description of each paper.

3.6 Critical appraisal

The research question was: ***'What are the experiences of clinicians and educational staff who use PBS?'*** The papers were categorised with a summary of aims, sample, methods, findings, and a critical appraisal, together with their limitations. Those critically appraised below are qualitative papers (n=10) namely Bambara *et al.* (2001); Lohrmann *et al.* (2008); Bambara *et al.* (2009); Perez *et al.* (2012); Lohrmann *et al.* (2012); Woolls *et al.* (2012); Inchley-Mort and Hassiotis, (2014); Andreou *et al.* (2014); Karger *et al.* (2018); Houchins *et al.* (2005). The quantitative papers (n=3) are Wills *et al.* (2013); Lowe *et al.* (2007); McGill *et al.* (2007) and the mixed methods (n=1) is Clark *et al*. (2020). The approach I have taken in presenting this critical review of each identified paper is based on results, keywords, themes, method used and comparison with the other papers. In this way, a thematic analysis is being undertaken and presented as a critical appraisal. The appraisal tools proved useful guidance in this process. The resulting appraisal of the identified studies includes the emerging themes, method and methodology, conclusions drawn, limitations, and assessment of the contribution that it would make to the overall purpose of my research.

3.6.1 Results

These 14 studies of PBS experience relate to the following: school environment, forensic services, learning disability services, training, and staff; one study (Houchins *et al.*, 2005) was from a juvenile environment categorised under the educational umbrella. Clark *et al.* (2020) and Karger *et al.* (2018) were the only two studies carried out in a mental health environment; they explore PBS experiences of MDT including nurses and relatives. Lowe *et al.* (2007) focused on staff experience, while Perez *et al*. (2012) explored the

perception of PBS from an OT perspective. These papers have a quality score of between 39% to 95 % as shown in Appendix 1.

Initial observations and analysis reveal a distinct lack of evidence of PBS experience from a mental health environment focussing unilaterally on nurses. The evident gap in literature created a strong argument for further exploration of PBS use in mental health services, particularly given the emergence of this framework in the contemporary health economy. The study by Inchley-Mort and Hassiotis (2014) scrutinises professional care managers (n=5) from supported living accommodation, with a mixed group of participants including 6 service users and 25 carers. While few studies were from a school environment, the observation is that investigation into the children's experience of the PBS approach seems absent as a contrast to viewpoints of educational staff. This might be explained by the ethical challenges and informed consent issues when working with children.

Findings from these varied different papers presented a persuasive rationale for research investigating the views of registered nurses as a separate group. All studies were either performed in the USA, Australia, or the UK, which reflects the origins and historical background of PBS and its present integration in the UK (see 2.3).

In terms of the overall sample characteristics within the identified papers, participants were either care staff in both supported accommodation and health service settings (n=354), or in an educational setting (n =157). The figures suggest some evidence of staff experience of PBS, but limited research exploring registered nurses' experience of the framework in mental health organisations. In the studies based within a care setting, participants had a minimum PBS exposure of at least 3 months (Perez *et al.,* 2012). This finding encouraged me towards the inclusion of potential participants in my research, which was to include registered nurses with at least 3 months of PBS training or exposure.

Data analysis used in the papers ranges across several different qualitative approaches including grounded theory, thematic analysis, and critical incident technique (derived from the principles of phenomenology) (Andreou *et al.,* 2014). A mixed approach to data collection, comprising interviews and focus groups, is seen in Woolls *et al.* (2012). The use of a qualitative approach (n=10) for capturing PBS experience of stakeholders is seen as most appropriate during this literature review and also applies to interviews as a method of data collection. Since PBS is a behavioural and processual intervention, entailing a shift not only in practice but also in attitude by practitioners and carers, it is most successfully researched via methods that pay attention to granular data, i.e., through qualitative methodology.

PBS does not seem to have been explored through the lens of ethnography, no process of observation, no interpretative phenomenological or hermeneutical approach.
Themes identified from the papers are:

- Knowledge and attitude
- Experience of PBS in relation to schools
- PBS as experienced within the care environment.

3.6.2 Knowledge and attitude

Knowledge and attitude are consistent themes from the studies that explore the experience of staff following a period of PBS training. Findings suggest an increase in knowledge and an improvement in staff attitude, with a strengthened understanding of behaviours that challenge. For instance, Lowe *et al.* (2007) took a quantitative approach to explore the effects of PBS staff training (n=205) when analysing knowledge and attitude changes, when measured by pre- and post-training questionnaires. While questionnaires are a useful way to capture participants' experiences, they do not engage the participants in a conversation, therefore, have limitations compared to interviews or focus groups where granular data can be captured. The study found significant improvements in knowledge and attitude, but little effect on emotional response. This is similar to the results of quantitative studies by McGill *et al.* (2007) and Wills *et al.* (2013). All three used questionnaires to evaluate their participants' experience. However, these studies do not necessarily address one of the important aspects of any training: its effects on the delivery of care, and how any improved knowledge, confidence or emotional responses are translated into practice. Training may not suffice to bring about positive change in practice as well as in attitude, human factors that are essential elements in any care intervention. A face-to-face interview would potentially have provided the opportunity to unpick and further examine participants' experience of PBS training as applied to their practice. Questionnaires are commonly used for convenience with large sample sizes, which may be why these authors opted for them rather than interviews. However, the completion of questionnaires offers no interaction and engagement with participants, which is critical for harvesting signs of understanding or evaluating personal experience. Combined use of interviews and questionnaires as a data collection method could potentially provide richer data concerning experience and delivery aspects in follow up evaluation of PBS training (Codo, 2009), despite the challenges of questionnaires taking some time to be returned to the researcher.

A follow-up approach was taken by Lowe *et al.* (2007) to assess the participants' perceived confidence after one year of delivering PBS training. Lowe *et al*. (2007) studied the

effects of PBS training on the attitude and knowledge of registered and unregistered nurses in specialised health services. The study evaluated a one-year PBS training programme before and after which staff were asked to complete a questionnaire. The outcome revealed that PBS training was positive in terms of acquiring knowledge and confidence, but the staff did not feel it had influenced their emotional responses. However, their ability to deliver services for people with challenging behaviour had improved. Due to the difference in level of responsibility and accountability, it would have been useful to see registered nurses' personal experience of PBS as a separate set of findings. However, this was not the stated aim of the research. Furthermore, the participants were not asked about what an improvement in challenging behaviour would entail and how changes might be measured. While knowledge and confidence may change, it is yet to be established *how* training brings the required changes in practice; a question which a face-to-face data collection method would have addressed.

McGill *et al.* (2007) used questionnaires and different scales to evaluate 79 staff experiences of PBS following a university-based PBS training. The participants expressed positive emotional responses regarding anger and depression. Staff experience was found to have improved as well as the causal attributions to challenging behaviour. Results of this study endorsed the findings of the university-based training. However, limitations to this research include an evaluation that does not measure or compare the effects of training between intakes, that is, how this specific intake of students compared to another group. While PBS is a practice that requires careful and systematic application it is useful to explore the experience of staff who have applied the intervention in practice in order to better understand barriers and challenges and address them. For these reasons, this finding does not provide useful insight into the effects of training on care delivery, nor does it offer granular data on experience, reflexive evaluations, or the care provider's interaction and relationship with their patient.

Wills *et al.* (2013) used a quantitative approach to evaluate staff knowledge, attributions, and emotional responses in a study that investigates the post-training attributes and beliefs of frontline staff. It involved capturing the staff experience of working with individuals who display behaviours that challenge. This study consisted of a comparative analysis between a period of pre- and post-PBS training and required participants to complete a questionnaire at both stages. Data analysis revealed that after training staff felt increased confidence, improved understanding, and a greater awareness of challenging behaviour; they also felt assertive enough to implement least restrictive interventions and felt an increased

sense of positivity in their attitude towards challenging behaviour. The outcome from Wills *et al.* (2013) resonates with other studies mentioned above, in that PBS training increases knowledge about the causes of challenging behaviour, optimism, and how to offer proactive help. However, Wills *et al.* (2013) related to training delivery in a hypothetical case of someone with a learning disability and behaviour of concerns. The study's questionnaires were purposely designed to take less time to complete; this was to improve recruitment. A relatively short questionnaire, although it might still capture vital and useful data, may raise the query of whether it would obtain a sufficiently rich set of data. This approach may have missed vital evidence regarding staff experiences of PBS. An important factor to observe in Wills *et al.* (2013) relates to the participants: 59 staff started the training, but only 38 staff completed the course and the questionnaires. The remaining 21 staff did eventually complete the training and the questionnaires, but their data were not included in the study. So, it should be clarified that a large sample of 21 staff was not included, which may well have provided a different set of findings. Part of the questionnaires in the study included a series of multiple-choice questions that staff needed to select from. This approach may restrict them from answering questions in their naturally chosen manner and prevents them from expressing their experience in their own words. It is also observed that Wills *et al.* (2013) used no control or comparison, nor there was any follow-up evaluation.

3.6.3 Experience of PBS in relation to schools

Only few of the identified main papers referred to a school environment. My wider reading has uncovered a wealth of available evidence depicting the role of PBS in schools. One instance, a study by Dunlap and Carr (2007), records a detailed exploration of the effectiveness of PBS as a successful framework in school settings, supporting children from an early stage of their identified behavioural issues. Other literature too portrays the benefits of PBS in school environments (Sugai *et al.*, 2000; Horner, 2002). Dunlap and Carr (2007) emphasise the importance of initiating PBS intervention with children at a primary phase during challenging situations. Moreover, the literature describes PBS as a framework that engages families and other significant stakeholders in supporting difficult behaviour in quite young children, as well as developing their ability to work in partnership with a range of professionals.

Five themes emerged from the qualitative research by Bambara *et al.* (2009), a paper that explores a school team experience of PBS. namely, 'school culture', 'administrative leadership and support', 'structure and use of time', 'on-going professional development' and 'family and student involvement'. The participants in this study consisted of internal and

external, mostly female, PBS facilitators (n=22 out of 25). One observation of this research is that it brings an external perspective to the findings, hence the themes could be argued to have been influenced by the external facilitators. The external facilitators may not hold the same values and vision of the school concerning their PBS position, which may influence the findings. Substantive school staff would, arguably, be more aware of the PBS barriers and facilitators within the school compared to the external facilitators, although this is dependent on how long the external facilitators have worked there. One example is the theme of 'school culture' that emerged. As in Bambara *et al.* (2009), 'leadership' is a theme that also emerged in Lohrmann *et al.* (2008) where an open coding method analysed the data from 14 educational consultants. However, Lohrmann's study did not involve the school staff, plus the external consultants (n=14) involved were highly qualified with PhDs and Masters' degrees, so its findings could be argued as being specific to highly trained individuals. It could be argued that the themes (leadership, scepticism, hopelessness, security, and comfort) from Lohrmann *et al.* (2008) were not a pure reflection of the experience of the school staff per se. In a later study, Lohrmann *et al.* (2012), four themes emerged: 'barriers', 'climate/system influences', 'resolution contributors' and 'resolution status'. Themes related to barriers, leadership and culture also run through the study of Andreou *et al.* (2014), which used the principles of phenomenology (specifically, critical incident technique) to interview 17 educators, including 12 females, about their school experience of PBS. The strength of Andreou *et al.* (2014) is that they used a phenomenological approach that is appropriate when trying to understand lived experience of a phenomenon (see 4.2.2). Data collection was through semi-structured interviews.

Evidence describes PBS as a valuable paradigm that ensures school and home environments are suitable for children who display behaviours of concern; an environment conducive to their transition (Bambara *et al.,* 2009). Additionally, PBS is considered a practice that reduces children's future extreme behavioural issues without impacting their academic abilities (Dunlap and Carr, 2007). Evidence shows that when children are exposed to PBS at a young age, there is a minimum subsequent risk of social exclusion and segregation (Vincent and Tobin, 2010). These claims are supported by a large collection of data compiled over twenty-five years' implementation of PBS in school environments and establish that PBS, when skilfully implemented, provides quality interventions that address behavioural issues in children (Lowe *et al.,* 2007). However, the prerequisites for effective PBS in a school environment still remain unclear, despite a review of the existing evidence. There remains poor understanding of how application of the framework would translate into a

clinical setting. Given the success of PBS in schools, it would have been useful to fully appreciate the effectiveness of the core components of the intervention and how they were implemented. Exclusion or segregation resulting from unstable family dynamics; difficult upbringing, an unstable family, abused children, and those who feel bullied are common factors that may have significant implications on children's behaviour and academic performance. They all have significant bearing on children's behaviour and school performance that need to be contextualised within a discussion of PBS (Zych *et al.*, 2019) and further exploration would be extremely useful in the school context.

3.6.4 PBS as experienced in care environment

Bambara *et al.* (2001) explore staff experiences of PBS in a learning disability and challenging behaviour context. Other studies that explore staff experience in a care environment include Lowe *et al.* (2007), Perez *et al.* (2012), Woolls *et al*. (2012), Karger *et al.* (2018), Clark *et al.* (2020) and Inchley-Mort and Hassiotis (2014).

Karger *et al.* (2018) explore the experience of 11 staff, comprising healthcare assistants, nurses, a psychiatrist, occupational therapist, and clinical psychologist. As such, the study aimed at explaining an MDT experience of PBS. It used thematic analysis to investigate staff experience in a forensic adult mental health setting within an NHS organisation. Data collection was through semi-structured interviews. Karger *et al.* (2018) was considered significant as it comprises views of NHS staff. While PBS is a framework that requires a team approach, it is useful to be informed of the MDT views. The themes that emerged from the study were from an MDT perspective consisting of 2 mental health nurses.

Karger *et al*. (2018) concluded that, within that service, PBS was well received by staff across disciplines. Staff identified barriers such as having to adapt the intervention and consider certain organisational issues of leadership that impeded the delivery of high-quality PBS. Identifying these barriers was found to be valuable observation. However, Karger *et al*. (2018) did not record separate accounts from each discipline therefore it was not possible to ascertain and fully appraise, for example, what the 2 nurses' experiences were in comparison to other professionals. The staff had an average of 6–24 months of PBS training when interviewed, suggesting that a minimum of 6 month's PBS training was deemed adequate to acquire knowledge and awareness of PBS in this situation. A sample size of 11 was found appropriate for a thematic analysis as saturation was reached at the 6th participant. The lack of professional homogeneity in the study may also be a limitation in the sense that different disciplines have varying professional backgrounds and cultures in which staff may come from unique and diverse professional formations. This is in contrast with Perez *et al.* (2012)

where participants were occupational therapists with a minimum of 3 months PBS experience. One argument that explains the relatively lower experience of participating staff may be that PBS is a relatively new approach in mental health and learning disability services, making it a challenge to recruit staff with extensive knowledge through formal training. The OT in Perez *et al.* (2012) referred to 'challenges', 'understanding behaviour', and 'support' as the main themes. This is parallel to Bambara *et al.* (2001) which highlighted the need for support and for greater insight into behaviours. A sample of 10 in Perez *et al.* (2012) was considered adequate for thematic analysis as their aim was for a richness of data alongside details of the experience as expressed by the participants' own words. The study used semi-structured interviews, and this was found to be a useful data collection method. However, it did not use face-to-face interviews; these were conducted either through telephone or Skype. Therefore, interviews both face-to-face and via digital means were deemed acceptable methods. However, in Perez *et al.* (2012) offer no detailed participants' characteristics other than that 5 were 'senior' OTs. A lack of participants' details may bring some challenges when placing this study in context. For instance, analysing narratives against each participant's level of OT experience and their area of work would have been useful. Instead, the level of experience is presented as an average.

Woolls *et al.* (2012) adopted a grounded theory approach in which 14 participants (3 males; 11 females) took part consisting of direct and indirect care staff. The core themes in Woolls *et al.* (2012) were 'internal/external support', 'service delivery', 'mediators' and 'delivery of PBS' (Appendix 3). The data collection method was divided based on participants' role. Registered nurses (n=3), unregistered nurses (n=1), social workers (n=3) and social care manager (n=1) were interviewed, while clinical psychologists (n=2) and behavioural specialists (n=4) participated in a focus group. There was no rationale or explanation as to why and how the participants were grouped in each of the data collection methods apart from that they were direct versus indirect care staff. This separation seems to suggest an underlying assumption that direct care staff's experience of PBS would be different from that of the other staff. Further, it is noteworthy that clinical psychologists were considered to be 'indirect care staff', implying that their role in PBS was not the same as that of nurses. Another criticism of Woolls *et al.* (2012) is that the experience of the participants and level of their PBS training was unknown and only presented as an average.

Lowe *et al.* (2007) have been discussed above. However, their study explored the PBS experience of care staff and therefore requires further comment. Its limitations centre around the sample attrition rate where only 122 participants took part in the attitude questionnaires

(from n=205), meaning that a full data set was not available. Clark *et al*. (2020) evaluate the understanding of mental health nurses (n=13) and relatives' attitudes (n=7) towards PBS in mental health care. This is another significant study due to the involvement of registered nurses. The study establishes that PBS was not implemented consistently within that setting, and mental health nurses were often unfamiliar with, and even confused by, the PBS model. This could be primarily due to the slow advancement of PBS in mental health services. One registered nurse said:

> '(We use it) if a patient is presenting aggressive or abusive and presents a risk for the other patients and staff.' (p.145)

The findings in Clark *et al.* (2020) demonstrate that some staff had little understanding of what individual behaviour meant or the function it serves. However, most nurses and relatives valued PBS and welcomed its benefits. This study, although useful, did not report on how long the staff had used PBS in practice, which would affect their experience of the framework. It was not clarified whether staff had any PBS training and how much they knew of the intervention. The study examined staff experience of PBS in relation to their understanding of complex behaviour and restrictive practices. It used thematic analysis to analyse the data. The interviews in Clark *et al.* (2020) lasted between 15 minutes and an hour, which may either imply that some participants may have little to say or that they find interviews difficult.

In Inchley-Mort and Hassiotis (2014), 25 carers and 6 service users were interviewed in a behaviour specialist service and data analysed through thematic analysis. There was a convenience sample for this study, and the themes that emerged were: 'availability and frequency of contact', 'talking about behavior and being listened to', 'being understood', 'change', 'longer engagement and crisis support', and 'challenges'. The challenges referred to were organisational, communication and workload; all relevant to the concept of leadership as discussed in Lohrmann *et al.* (2008), Bambara *et al.* (2009), and Houchins *et al.* (2005) albeit in various settings.

While Inchley-Mort and Hassiotis (2014) are amongst few that explore the experience of service users, there remain limitations, including the way data was collected. Carers were present alongside service users during some interviews, which may have influenced participants' accounts and make them less willing to censure critical services or care. In some situations, the service users talked less when being recorded compared to when the audio

recorder was off. Therefore, the reliability of the data should be accepted with reservations. Further, it is found that many service users were excluded from the study due to their limited verbal skills or inability to give informed consent. Informed consent appears to be a significant barrier to service users' participation.

3.6.5 From a juvenile setting

'Ecological congruence' was one of the themes from Houchins *et al.* (2005), a study from a juvenile setting. 22 participants (F=14, M=8) took part in this study that adopted grounded theory, a bottom-up approach that aims to build theory inductively and in an experience-near framework, rather than using a top-down and potentially experience-distant deductive model, which can lead to significant data being overlooked. The correlation between power, control and punishment is a useful concept that developed in Houchins *et al.* (2005), where participants were able to position PBS in a correctional environment. 7 clinical staff participated in the focus group but there is no indication of their professional status as registered nurses or from other clinical groups; they were referred to as 'treatment director', 'service worker' amongst other titles. All participants had received PBS training in the previous eighteen months and had varying levels of experience. As there was no information on individual training levels and their experience was presented as an average, the data could not be analysed from an angle of individual characteristics.

3.7 Summary of findings

The themes that emerged from the identified papers through the literature review demonstrate strong support in favour of PBS in various settings; although the practice requires more extensive research in mental health and learning disability services, especially from a nursing perspective. The literature review evaluates a wide range of stakeholders' experience of PBS. Studies have included a range of professionals such as registered and unregistered nursing staff, teachers, family carers, a clinical psychologist, a psychiatrist, educators, consultants, and occupational therapists. However, these individuals have been part of multi-disciplinary perspectives except for Perez *et al.* (2012), where the experience of OTs was explored unilaterally. Registered nurses' experience of PBS has not been evaluated as an independent group. Thus far my literature review has indicated a gap in the evidence base regarding registered nurses' experience of PBS as a sole professional group. Such a knowledge gap indicates an under-explored area in the field of PBS, which should prove valuable in advancing its effective application to an increasingly high standard. Registered nurses, as frontline care workers, have a significant role to play in the administration and

evaluation of clinical interventions and, as such, their views of PBS in a mental health organisation will provide valuable academic material.

3.8 Gap in literature and justification for my research

Thus far, from the literature review, it has become evident that PBS has not been explored from a registered nurses' perspective as an independent group. Their viewpoint is important for the advancement of PBS in mental health services as there is a drive to implement the framework more widely in areas of behaviours that challenge. Registered nurses play an important role and contribute enormously to evidence-based practices. Therefore, an understanding of their experiences of PBS as an independent group is significant in informing practice. Nurses spend considerable time with patients and service users compared to other disciplines, so their experience of PBS is central to the development of policies, protocols and support systems that require informing from further research. This gap in current literature provides strong justification for my research, especially when PBS is gradually becoming a preferred option in the care of behaviours that challenge. The literature review demonstrates an emphasis on behaviours that challenge in three main areas: school environments, mental health settings, and learning disabilities services. As nurses are key players and paramount in the delivery of PBS, their contributions to its application are valuable in advancing the practice and improving the welfare of service users, families, and other stakeholders. PBS remains under-researched in mental health services as identified from literature searches.

Based on the literature review, no study has used ethnography, hermeneutic phenomenology, or constructivist grounded theory, while thematic analysis and semi-structured interviews have been useful methods for previous studies. A few large-scale quantitative studies and qualitative studies have been identified from the literature review process, but there appears to be no study based on process or observation of process and implementation. The rationale for using a qualitative method for this study is also underpinned by the context of the study, the aims, and objectives it sought to achieve and the resources available at the time of the investigation. The timeframe to complete this research has also informed, to a certain extent, the methods and methodology.

3.8.1 Aims of this research

My study took place within an NHS trust to explore and understand nurses' experience of PBS. Its broad intention is that the findings contribute positively to the development of

PBS in the context of challenging behaviour- and to study it through the nurses. The study is underpinned by the following three questions:

- What is the experience of nurses of using PBS in clinical practice?
- What are the challenges that nurses have encountered (or still encounter) during the implementation of PBS and how were/are these difficulties being addressed?
- What are the enablers for effective PBS from a nursing perspective and what is its usefulness in behaviours that challenge?

Aims of the study as underpinned by the literature review:

- To explore registered nurses' experience, including their knowledge and understanding, of PBS.
- To generate new knowledge and contribute towards the existing body of evidence on PBS.
- To explore any evidence in current literature concerning nurses' experience, knowledge and understanding of PBS, and to address any gaps that are identified.
- To exploring the findings, and to make recommendations towards the advancement of PBS in a mental health context.
- To identify any support that nurses would require to embed PBS in the day to day practice.

3.9 Conclusion

This chapter has provided a detailed account of the steps I undertook to review the literature based on a specific and focussed research question. It has presented a detailed process and the findings from the literature search. It concludes by suggesting that there is a lack of evidence of registered nurses' experience of PBS as a separate group. The next chapter will discuss the methodology selected for this study as informed by the literature review.

4.0 Methodology

4.1 Introduction to chapter

In this chapter, I discuss the methodology and method used for this study, founded upon the findings of the literature review regarding the methodology, method, and sample. From the methodological viewpoint, I will explore the epistemological and ontological positions that support the study's approach and research design. I will also explore reflexivity, my role in this research and relevant ethical considerations. This chapter provides a detailed account of data analysis using thematic analysis and hermeneutic phenomenology as a theoretical framework.

The Gantt charts in Appendix 4a and 4b present an overview of my workplan. Appendix 4a shows the anticipated timeframe for this project, while 4b is a revised version of the chart to reflect the actual timeframe.

4.2 My Ontological and epistemological position

In deciding on the methodology that could potentially fit this study, it was essential to acknowledge the inter-relationship that exists between methodology, method, and the researcher's ontological or epistemological position (Crotty, 1998). I understand that a researcher's ontological and epistemological stance has a powerful influence on the chosen methodology for the research, including its data collection and analysis (Crotty, 1998). Ontology refers to what we believe can exist, and what we assume is fundamental (Crotty, 1998). Ontology is concerned with being; what is there and what exists (Guba and Lincoln, 1994). It can position the researcher at a standpoint of either realism or relativism (Guba and Lincoln, 2000). Epistemology is concerned with knowledge; what constitutes knowledge and where we derive knowledge from (Crotty, 1998). Epistemological positions exist on a continuum, ranging from positivist to interpretivism through the critical-realist position (Guba and Lincoln, 1994). As a clinician, my experience leads me to believe that that the existence of multiple truths is important. This supports the interpretivist position whereby each participant is given the opportunity to offer their unique perspective. My belief about the acquisition of knowledge is linked to the notion of multiple truths, therefore I took an interpretivist position from which realities are best understood through the interactions of differently situated agents, allowing the researcher to consider various perspectives (Creswell, 1994). Epistemology can be referred to as the theory of knowledge, and in this current study, the epistemological stance lies within the interpretative paradigm – where the

focal point is about exploring multiple truths and unravelling the participants' experience of PBS.

This is best demonstrated by my experience of growing up in a developing country before coming to the UK in the late 1990s for further studies. Growing up as a child, and through my early academic studies, I was taught an understanding of reality as something that never changes. I was led to believe that there is one truth, and I would remain committed to that single truth. However, through life experience, and through my professional training, my perspective of what constitutes the truth changed, and I found myself reaching agreement with academic positions that increasingly claim that there is no single privileged position from which to understand reality or any single truth. For instance, in the past, when not living within Eurocentric cultural norms, I have viewed people with physical disabilities to have a poor quality of life and have often felt sorry for individuals with physical impairments or disabilities. I have learnt over the years, living in a Eurocentric culture, that while individuals with a disability will live a life that may be different from a fully abled person, this does not necessarily mean that their quality of life is poorer. I have come to understand that the quality of life of people with or without a disability depends on so many factors and is most importantly based on their personal life experiences. My professional training as a learning disability nurse has allowed me to further my concept of truth about disability (physical or intellectual) as shaped by each individual context. Therefore, progressing through my professional and personal life, I have experienced and been a part of my paradigm shift from naive realism towards relativism. In this shift, I have found a new lens through which to view the world in a certain way, not just regarding disability but in many aspects of life.

Informed by my life experience and professional training as a nurse I have become more aware of the nature of truth, the make-up of the world and how I exist in that world. I have come to accept that people's experiences and stories (their reality) can be best evaluated subjectively, which aligns with Bader and Malhi, (2019) in which individuals have unique sets of experiences and understandings of those experiences; this had led to my interpretivist position. Bader and Malhi (2019, p 477) talk about researcher's unique values and interests that motivate their work, claiming that 'over the course of our careers, exposure to new theoretical ideas, scholars, and methodologies shape how we do our research'. I have come to understand and accept that I do not have to level the world with a single view but to acknowledge the coexistence of many possible meanings of people's experience, particularly in my professional life with my patients and their families. Correspondingly, in this study, I embraced an interpretivist viewpoint, to better engage with these multiple truths, the

discovery of which is best achieved through interaction with my participants and where there is a journey of explication, understanding and meaning, rather than linear cause and effect (Allsop, 2013). I strongly believed, and proposed, that the experience of registered nurses concerning PBS needed to be explored through the 'how' and 'why', and through social interaction, so that the specific truths of those nurses were fully understood. From my position in this research in terms of epistemology, ontology, and the production of knowledge, together with my positionality as a nurse with a wide-ranging professional experience of different locations, I have found that reality is subjective and multiple and as seen by the participants involved in a study. Positivism focuses on the 'how' and the trends, rather than offering deeper explanations to the 'why'. In section 4.4, I demonstrate how I maintain a balance during this study between the participants' truths and my subjective interpretation of their truths.

4.2.1 Methods of Analysis

The literature review detailed in Chapter 3 has not identified any studies that utilised ethnography, phenomenology, or grounded theory in PBS. Equally, no studies were discovered that explore nurses' experience of PBS as a unique group, from either a quantitative or qualitative perspective. However, it was equally evident from the literature review that qualitative research is the much-preferred approach when aiming to capture lived experiences (see 3.6.1). Further, qualitative research is situated within a relativist paradigm and is strongly linked to the interpretivist position I have taken (Golob, 2019; see 4.2). I contemplated a few methodologies as potential frameworks: ethnography, Grounded Theory (GT), constructivist GT and hermeneutic phenomenology. These methodologies were potential candidates based on the findings of my literature review and when considering the best means for facilitating understanding and explaining sets of values, behaviours, beliefs, and ways of life among people who share a common culture (Creswell, 2007). There was no process of elimination from face value, rather it was vital to explore, compare and analyse the strengths and weaknesses of the selected methodologies in connection to the research question. The most suitable methodology to address the research questions were considered (see 2.6).

Ethnography was a potential methodology for this project, firstly, because my initial thought was that it may answer the aim and objectives of my study. Secondly, the sample of registered nurses was likely to satisfy the cultural classification of ethnographic studies, as a 'social group'. However, Schensul *et al*. (2013) argue that the primary feature of ethnography is grounded within fieldwork, and that observation is the most appropriate method for data

collection- which involves the researcher being in a clinical environment observing and evaluating the use of PBS in a care provision context. Considering my role as a consultant nurse this may seem an appropriate methodology, but it would have been against the aim of my study, which was to explore the lived experience of my participants in the way they wish to voice it: in their own words. Although ethnography could provide a framework in which to explore culture, through both observation and listening to participants in context, it was not the perfect fit when it comes to capturing and understanding their experience. I accept that such situated observation can be particularly valuable and places less reliance on participants' ability to verbally communicate their job role and experience. Nevertheless, the central focus of an ethnographic approach is to devise a portrait of the culture at work. This, though useful, would be a departure from the primary aim of my research; to explore and understand my participants' experience of PBS in their own words (perceptions, evaluations, and opinions).

In ethnography, data collection may include participant observation with fieldwork notes, interviews, focus groups and surveys. It was not the aim of my study to observe PBS in action nor to evaluate its implementation in practice, but to give registered nurses a voice to share their experience of PBS. For this reason, interviews provided the most appropriate way for the nurses to tell their truths of their experiences, and this method of data collection enhanced the richness of the data and fits the aims of this study. An ethnographic approach would not necessarily capture the experience of PBS as expressed by the nurses; instead, it would have focused on why the nurses behave in a certain way. Therefore, ethnography could not serve to achieve the research aim. In fact, in ethnographic studies, the researcher 'lives like and lives with' the sample population to study its everyday behaviour (Wolcott, 2008). If, as a nurse consultant, I were to base myself in the care environment, I could potentially disrupt the natural process of care delivery. I also foresaw an issue regarding cost-effectiveness using an ethnographic methodology: being in the clinical area would take me away from my day to day role and responsibilities as a nurse consultant by having to wait for an event to take place in relation to PBS. Another challenge could arise about being accepted in the culture of the clinical environment in the role of researcher. If my study had a primary objective to observe PBS practice in a given environment, assess the implementation of PBS, or to explore the experience of the nurses through debriefing within any particular setting (assuming ethics, safety and consent were addressed), ethnography would have been appropriate as it allows a study to take place within its 'natural habitat'. Furthermore, LeCompte and Schensul (2010) contend that in ethnographic research, observing participants or understanding experience through debriefing is mainly geared towards understanding a

subject's behaviour in terms of actions and interactions within an environment. To achieve this, it is necessary to have an action and interaction during which participants engage in each context for a period (LeCompte and Schensul, 2010). Ethnographic studies do not focus upon the essence of people's experiences, because this tradition of enquiry is particularly interested in the analysis of a culture-sharing group, cultural behaviour, social structure, and organisational patterns (Creswell, 2007). My role in an ethnographic methodology would have been to record nurses' human behaviour in cultural terms. Such elements are intrinsic in the process of "experiencing activities in a group", but this is not the focus of my study.

Ethnography often requires an extensive and long-term involvement, and could mean spending many months on sites, exploring how culture shapes experience, instead of depicting what the experience is (Munhall, 2012; Creswell, 2007). This implies that less weight is placed on the interpretation of participants' experience, which was a further rationale for my excluding the ethnographic method.

Grounded Theory (GT) was also considered for this study, although the literature review indicated limited research using this methodology. Creswell (2007) describes GT as an approach that allows examination of experiences by those who share a common culture but where the goal and end product is the production of a 'bottom-up' (as opposed to 'top down') theory, rooted in ethnographic or other close work that reports on the cultural and holistic meaning of a phenomenon through observation or debrief following a particular activity. GT is often used to understand social problems or conditions to which people must adapt. It explores social circumstances that influence individual or group experiences and behaviours (Glaser and Strauss, 1967; Charmaz, 2006; Corbin and Strauss, 2008). It was determined that GT was not an appropriate fit for this research, because it is primarily aimed at developing a substantive theory, grounded in data, while the aim of this study was primarily to understand nurses' personal and contextual truths about the world (PBS) around them. Moreover, GT was not considered appropriate because PBS is already well situated in literature, as identified in Chapter 3's review. GT differs from phenomenology because in GT the researcher tends to include all data collected in the formulation of theory (Strauss and Corbin, 1997; Charmaz, 2006), and, unlike phenomenology, GT uses a strategy of constant comparison through which collected data is compared with other data to identify contradicting cases, hence challenging the new theory that emerges. A core feature of GT that there is no preceding theory; instead, the theory is derived from the data. Because of my epistemological position and the aims and objectives of my study, it was felt that GT would not be the appropriate methodology for this research.

That said, Charmaz's constructivist GT was a further consideration. This version of GT takes a middle ground, which carries the advantage of making it flexible and less restrictive compared to the classic Glaserian and Straussian approach (Glaser and Strauss, 1965). Charmaz maintains that a degree of flexibility optimises research and that there should be a tangible relationship between participants and the researcher. This aspect seems absent from the original definition of GT, which attempts to achieve context-free generalisation by assuming that the researcher is neutral and passive – an assumption which I have rejected in taking my epistemological stance. However, the constructivist version proposed by Charmaz does acknowledge a researcher's values, positions and actions as having a great influence on the outcome of research (Charmaz, 2005, 2008). These elements were highly relevant to my position as researcher in the context of PBS. This variant of GT also accepts that reality is construed from meaning and that interaction between the researcher and participants impacts the interpretation of meaning, an argument that complements the point made by Strauss and Corbin (1990) who suggest, conversely to Glaser's position, that meaning is partially grounded in the data and that a vast majority of reasoning originates from the researcher's interpretation of that data. Indeed, constructivist GT was a serious contender as a fitting framework, but because it remains largely theory-driven rather than being interpretative, which was a core concern of this research, it was excluded.

Therefore, after thorough evaluation, it was decided that ethnography, GT, and constructive GT were all excluded as potential frameworks. The section below explains the rationale for selecting a hermeneutic phenomenological approach for this research, using Thematic Analysis as a method of analysing the data.

4.2.2 Hermeneutic phenomenology

This section provides a discussion as to why hermeneutic phenomenology was the most appropriate methodology to answer my research aims and objectives. The first justification was drawn from the study's primary aim. My research was situated within wider philosophical discussions about the principles of exploring the essence and meaning of individual experiences, as well as the value of such an enquiry. On the issue of subjectivity versus objectivity, Heidegger (1962) initially shared similar views to Husserl regarding phenomenological reduction (i.e. bracketing), a practice that emphasises laying aside any preconceptions or preunderstanding that may influence the research process. Husserl proposed that a researcher should suspend their judgement and beliefs about the subject being investigated and believed that by doing so a researcher could see and understand the phenomenon more clearly and without preconceived ideas. However, Heidegger has since

argued that the concept of bracketing limits the researcher's ability to fully understand the data being gathered (Laverty, 2003).

Although hermeneutic phenomenology is like phenomenology in its concern for exploring individuals lived and human experience, the difference lies in the way that the lived experience is analysed. Heidegger focuses on '*Dasein*', best described as the mode of being human with due importance given to embodied presence (Laverty, 2003; Crowther *et al.*, 2017). It is reported that Heidegger explains hermeneutics as another way of achieving a sense of understanding, while the understanding of a phenomenon is linked to an already established array of compositions (Koch, 1995; Laverty, 2003; Horrigan-Kelly *et al.*, 2016).

In his seminal work Being and Time, Heidegger (1962) defines and builds on his term *Dasein*, translated in English as 'there-being', which is concerned with the quality of human existence concretely situated in the world, namely 'worldliness'. *Dasein*, for Heidegger (1962), is 'always already' in people's pre-existing worlds of culture, objects and language and cannot be separated from them. This overlapping relationship with the world is conceptualised in the term 'inter-subjectivity' (Heidegger, 1962). The main aspect of *Dasein*, according to Heidegger, is the exploration of individuals' lived experiences and their interactions with the world, and these can only be accessed and understood through interpretation (Smith *et al.*, 2009). Heidegger deepened his analysis of hermeneutics, in providing a rationale for preunderstanding; namely, what a researcher brings to the process of understanding and interpretation. The concept of preunderstanding, as he described it, is not something that a researcher can easily bracket or suspend when attempting to comprehend a phenomenon. As Gadamer (2013) and Gyollai (2020) assert that the degree to which a researcher themself understands a phenomenon, and the complexity of that understanding, will inevitably affect their interpretation and analysis. There is no neutral objective ground, rather a series of possible grounds, variable according to a researcher's own life experience. Hermeneutic phenomenology is therefore about necessarily having a preunderstanding of the phenomenon, even if that preunderstanding consists of 'zero previous experience' of the area being investigated, and it is crucial to have a process of interpretation when the subject or phenomenon is being understood. I illustrate this through an example about the Madurai Meenakshi Amman Temple, a historic Hindu temple in Tamil Nadu, India. If three researchers, including myself, were involved in analysing materials from interviews about the temple, I may know certain things about the temple, the second person may know nothing and the third may know quite different facts about it. None of us would be right or wrong, but we would present specific positions as we relate to the world of the temple. These positions

necessarily influence our possibilities of unravelling and doing hermeneutic work on participants' interviews about the temple, resulting in three disparate analyses based on our personal preunderstandings. Based on this understanding, my position brought a unique perspective to interpreting the participants' experience of PBS; my interpretation would reflect my own knowledge, understanding and experience of PBS.

Hermeneutic phenomenology, as supported by Heidegger (1962) and Gadamer (2013), allows for a broader and richer understanding of the data, while simultaneously acknowledging that the researcher 'exists' in the participants' world and being (Ho *et al.,* 2017). Both writers propose that the researcher cannot distance themselves from the phenomena being investigated. I considered my PBS experience to be valuable in understanding other people's experiences. Furthermore, the hermeneutic circle, as endorsed by Heidegger, promotes the view that 'understanding and interpretation of [a] phenomenon is gained through shared knowledge and shared experience' (Reiners, 2012, p. 3) and I embraced this interesting position while undertaking this research. While the Gadamerian perspective on the hermeneutic circle is to consider the whole and the parts, both Heidegger and Gadamer agree that the circle is essential in understanding the phenomenon.

Smith *et al*. (2009) identify a process of double hermeneutic phenomenology during interpretation where the researcher engages in an exercise of interpreting the experience of participants who, in turn, engage in an exercise of interpreting their experience. This interaction with a phenomenon is a recursive process whereby respondents make sense of their experience and the researcher bring their own preunderstanding to bear on the material, so developing their insights into the respondents' understanding. Correspondingly, Heidegger (1962, p.195) argues 'not to get out of the circle but to come into it in the right way'. Both Gadamer and Heidegger consider it impossible to escape from our preunderstanding (Feher, 2016; Suddick *et al.,* 2020).

Another point of agreement between Heidegger and Gadamer that supported my epistemological position is the role of pre-understanding in hermeneutics, which sits within the interpretivist paradigm (Grondin, 2014). However, what makes Gadamer's standpoint unique is his departure from the concept of understanding as presented by Heidegger. Gadamer is of the view that the process of understanding in hermeneutics is grounded on a negotiation between the researcher and participants in order to arrive at an agreement about the phenomenon being studied (Suddick *et al.,* 2020). Although a shared understanding and new perspective is the essence of hermeneutic phenomenology, I questioned the view that agreement must be reached. This is because, as a researcher, I may never have agreed with

what my participants think of PBS and my understanding of their experiences was not aimed at influencing the situation to reach a consensus. Further, any attempt to negotiate understanding from my higher status as a consultant nurse in the organisation could have influenced the participants' outcomes and experiences in a way that Gadamer describes as 'the fusions of horizons' (Gadamer, 2004; 2013).

So, phenomenological designs and methodologies were the best fit for this research project, which aimed to provide an understanding of humans' lived experience of PBS while analysing and exposing the meaning of that experience (Salmon, 2012; Edwards, 2019). The two main approaches in phenomenology are descriptive and interpretive (Cohen and Omery, 1994; Matua and Van Der Wal, 2015). I aligned my research towards the interpretive (hermeneutic) approach as described by Heidegger (1962). Polkinghorne (1983) explains the interpretive process as one that enables a strong connection to our 'historicality', or to one's background and history, including one's view and understanding of the world (Horrigan-Kelly *et al.*, 2016). I needed to be fully aware of the influences that interplay within processes while trying to understand nurses' experience of PBS in a practical context. This understanding of wider context and historicality helped ensure minimal bias to the study, protecting it from undue subjectivity and personal influence in interpretation of the data.

Hermeneutic phenomenology allows for an exploration of experiences that reach beyond a mere description of phenomena, and so, my research involved more than simply gathering nurses' understanding of PBS (which would be descriptive). Rather, it aimed at analysing and understanding nurse experiences of using PBS, which requires an interpretative approach. By adopting hermeneutic phenomenology, I was aware that I did not have to suspend or bracket my prior knowledge and interests, including clinical experience of working in mental health organisations where I am constantly exposed to behaviours that challenge. This framework allowed an opportunity to be fully engaged in data collection and its interpretation without ignoring my own experience, beliefs, background, and interest in PBS. Section 4.4 discusses reflexivity, where I explore the steps taken to ensure my engaged awareness of unconscious bias that could have risen during the analysis, as well as establishing a commitment to on-going critical self-evaluation of my positionality as a researcher.

Additional ratification of hermeneutic phenomenology in studies like mine comes from Robinson (2002) and Finlay (2014), who identify the hermeneutic approach as flexible; an essential component for successful personal reflective and reflexive emergence during data collection and analysis. Additionally, taking account of my professional experience and

knowledge of PBS, hermeneutic phenomenology as informed by Heidegger and Gadamer allows for reflection upon the most current and up-to-date theory, research, and findings. (Alvesson and Skoldberg, 2017; Connelly, 2015). My role as nurse consultant in a caring environment harmonised comfortably with phenomenology and satisfied all the hallmarks that support this study, because my work as a nurse already consists of observing, interacting, interviewing, and understanding service users' circumstances, albeit no longer as a frontline worker. This deep understanding was essential towards supporting service users in their recovery. Being a clinician meant that I became instrumental, engaged and was an active player in data collection, analysis, and the interpretation process of this study.

Heideggerian hermeneutic phenomenology was deemed the most appropriate and suitable methodology for this study compared to GT, constructivist GT, and ethnography, not only because of its contextual fit, but because it helped answer the aim and objectives of my study in exploring nurses' 'existence' and 'life-worlds'. In this way, it helped explore nurses' experiences of PBS from both obvious and more ambiguous levels (Braun and Clarke, 2006, 2017). Therefore, based on the above arguments in this section and the fact that Heidegger's version of phenomenology allowed me to be present in the participants' world, as well wanting to embrace those views on understanding, this philosophical framework was the best fit to achieve my aims. By adopting Heidegger's hermeneutic approach, I was able to accept my knowledge and experience of PBS as positive resources in understanding the lived experience of my participants; it offered unique opportunities for a rich understanding when compared to other methodological approaches.

The first person is used throughout this thesis (see section 2.2) as a tool for acknowledging my connection and presence in the exploration of the lived experience of the registered nurses. By using the first person, I have acknowledged researcher immersion in the research process that supported my epistemological position. Besides this, there is an element within hermeneutic phenomenology that reinforces the need for a sense of contact with the participants, the study, and data analysis (Paley, 2016) that I wished to honour.

4.3 Semi-structured interviews

Crotty (1998) identifies methodology as one of the three key elements in any research process alongside ontology and epistemology, all of which inform one another. In other words, my ontological and epistemological perspective has informed the methodology, and, in turn, the methodology has determined the methods in this study.

The literature review undertaken in Chapter 3 identified a gap in the evidence base of PBS and identified hermeneutic phenomenology as the most appropriate theoretical framework to answer my research aims and question. Therefore, considering hermeneutic phenomenology as the methodology in this research, interviews and focus groups were deemed the most appropriate methods as they allow an iterative process to take place that captures a rich and in-depth understanding of a phenomenon. Focus groups share many common features with unstructured interviews. In a research context, focus groups aim at generating narratives and data on collective perspectives, and the meanings that lie behind those views (Webb and Kevern, 2001). Focus groups have many benefits and are useful in generating a rich understanding of participants' experiences and beliefs around a given phenomenon such as PBS. Equally there are limitations with focus groups, and one is about openness. There was the risk that participants may not feel comfortable in a group, especially if hierarchical issues exist within it, which may have subsequently affected their interaction with the researcher (Mansell *et al.*, 2004). A group setting may have impacted on participants' willingness to share sensitive details of their experiences due to a sense of being judged by fellow participants. I also felt that, in a group setting, participants may find it difficult to share their experience of challenging behaviour and PBS. In focus groups, participants may not wish to raise organisational issues, policy gaps and other service issues out of concern that what was said could be repeated outside by other participants (see the comment made by RNLD 12 in 5.3.5.1).

An additional hindrance is that the interview schedule for focus groups does not generally offer much structure, which means a situation could have risen where the set questions may not be answered (Acocella, 2012). During focus groups, there was an added risk that the researcher could assume the role of the moderator, thus preventing full immersion in the conversation (Mansell *et al.*, 2004). My research, while using a phenomenological approach, required the participant to describe their experiences in an 'uncontaminated' way which makes a group method of data collection with interactions between multiple participants incompatible with phenomenological research (Webb and Kevern, 2001). With focus groups, it is often difficult to clearly identify individual messages from each participant (Baillie, 2019). Discourses are influenced by the current context and often be driven by individuals with strong personalities. Taking all these points into account, and based on the research aim, my ontological and epistemological position, and my identified methodology, use of focus groups was excluded.

In phenomenology, and most qualitative research, individual interviews are the preferred method of data collection because they facilitate an in-depth interaction between a researcher and participant that helps extract a rich uncontaminated data set (Flood, 2010; Munhall, 2001; Low, 2013). Further, the essence of phenomenology is that it 'thematizes the phenomenon of consciousness, and, in its most comprehensive sense, it refers to the totality of the lived experiences that belong to a single person' (Giorgi 1997, p.236). This consolidates the argument that interviews seek the essence of phenomenological studies (Webb and Kevern, 2001). Interviews ensure that individual experiences can be more thoroughly investigated, clarified, and queried at a personal level without the external influence of a group, by using different prompts to seek clarity from participants by extending the description of their discourses, and helping to reflect on the themes that emerge.

There are numerous ways to conduct research interviews within the headings of structured, semi-structured and unstructured (Minichiello *et al.*, 1999; Lewis, 2015). Semi-structured interviews enable a deep understanding and a detailed exploration of the participants' experience as long as a fruitful relationship is established between researcher and participant (Webb and Kevern, 2001). Smythe *et al*. (2008) support a semi-structured approach in phenomenological research. This method allows for development of an interview schedule that enables the researcher to pose the questions that need exploring, to be absorbed in the play of conversation, and to embrace the principles and philosophies of the phenomenological spirit, which is not the case in heavily structured or loose unstructured interviews (Smythe *et al.*, 2008). In general, semi-structured interviews offer participants the opportunity to verbalise their experience in their own words and provides a platform where narratives can be unpicked in appropriate depth (Flick, 2009; DeJonckheere and Vaughn, 2019). The process can be supported by prompts, probes, and appropriate queries from the researcher. Semi-structured interviews are most likely to produce a rich and broad outcome from participants, that reflect the principles of capturing lived experiences sought by hermeneutic phenomenology (Lauterbach, 2018).

The flexibility inherent in semi-structured interviews compared to other interview techniques has been well documented (DeJonckheere and Vaughn, 2019). Despite different methods of data collection in phenomenological research (Van Teijlingen and Ireland, 2003; Sloan and Bowe, 2014), semi-structured interviews continue to be described as both adaptable and powerful qualitative methods (Galletta, 2013). Semi-structured interviews, in relation to hermeneutics provide participants an invaluable opportunity to describe and

explore their lived experiences (Liamputtong, 2011). This method fits well with my epistemological position of interpretivism, and the broader research philosophy used (see 4.2). Where interviews are the preferred method of data collection in phenomenology, they offer opportunity for participants to reflect on their experiences, making the method beneficial in terms of the emergence of data (van Manen, 1997; Sloan and Bowe, 2014). Van Manen (1990, 2016) referred to this occurrence as borrowing narratives and accounts from participants to construct understanding. This borrowing process allows participants to communicate their stories in a reflective manner (van Manen, 1997; 2016). During semi-structured interviews, the possibility arises to verify credibility and validity by exploring narratives and stories in the required detail through a conversational relationship that develops trust and encourages mutual discovery (Liamputtong, 2011). A few open questions are sometimes are all that is needed to generate useful data, with no further guidance to participants (Wood, 1991). This principle helped promote positive interaction and conversation between myself and participants during the phenomenological interviews I conducted. Semi-structured interviews, situated in the middle of the continuum, require open-ended questions to obtain specific information and enable comparison across cases; interviewers nevertheless remain open and adaptable so as to probe individual participants' stories in finer detail (DiCicco-Bloom and Crabtree, 2006). The interviewer thus asks all questions of each respondent but may pursue particular areas in greater depth as they emerge for each interviewee (Hill *et al.,* 2005; Hill *et al.,* 1997) and may vary the sequence in which questions are asked. The protocol serves as a guide in such interviews (Flick, 2002), which are constructed upon a foundation that incorporates creativity and flexibility to ensure that each participant's story is fully uncovered. Based on the above reasoning, I decided to use semi-structured interviews as a data-collection tool.

Due to the Covid-19 pandemic, some interviews (n=9) took place through Microsoft Teams (MS Teams) digital platform as an appropriate way of proceeding despite social obstacles (Perez *et al.,* 2012). I met with each participant either face-to-face or via MS Teams for approximately hour-long sessions. Participants who were interviewed in person met on hospital trust premises if they wished, and meetings took place in a comfortable meeting room away from interruptions or distractions. The nurses were offered breaks and water, and the interviews were conducted at a pace and location suited to their individual needs, such as at a venue closer to work or away from their unit. Those interviewed during the Covid-19 pandemic were offered choice between a face-to-face interview or via a digital platform. Once choices for a face-to-face meeting were respected, I ensured infection control measures

were in place to guarantee everybody's safety. Research ethics were set in place and followed: participants gave informed consent, were made aware of their right to withdraw at any time, informed that all garnered materials would be anonymised and stored securely in a password protected computer.

Use of an interview schedule is a common component of research, particularly useful in semi-structured interviews because it acts as a framework through which to present appropriate questions and prompts (Choak, 2012). The interview schedule I designed (Appendix 5) provided guidance, and a degree of flexibility intended to give the participants a platform to express themselves freely without being limited by the questions. A central aim was for the interviews to form a conversation during which the nurses could do most of the talking in line with the hermeneutic approach (Lauterbach, 2018). I felt an interview schedule was necessary to guide the interview process (Appendix 5) and developed it in relation to the literature review (see Chapter 3, and section 4.3) where different themes emerged. Each question and prompt on the schedule are linked to themes from the literature review as shown in Appendix 5. For instance, the literature review identified certain barriers that arose during the implementation of PBS, making it important to capture the participants' experience around the effectiveness and challenges of PBS implementation. The questions were subject to discussion and reflection with my supervisory team and a professional colleague with extensive research experience, to confirm they were coherent and consistent with the aim of the research. This process also streamlined the questions to make them more succinct. Before this process I assumed that participants would face barriers while using PBS, so the question was worded: 'How did you overcome barriers or challenges when using PBS?' Further to discussion with colleagues, I modified the question to: 'From your experience, are there any barriers to the effective implementation of PBS?', then updated it so I could expand on any aspect from previous interviews. For example, when one participant mentioned challenges and barriers during PBS implementation, I added a further prompt to question 7 of the schedule (Appendix 5): 'How did you overcome these barriers if any?'

The interviews were recorded by consent and then transcribed verbatim. Participants did not consent to publishing the full transcripts of their interviews in any way, which was respected. Otherwise, I intuited a risk that participants would not feel free to discuss issues related to poor service, or gaps in organisation policies and culture, as discussed in Chapter 5.

4.4 Reflexivity

My understanding of reflexivity in qualitative research is that it is a process of a continuous internal conversation and undertaking an on-going critical self-evaluation of my

positionality as a researcher; also of acknowledging that my position may influence the research process and outcome (Bradbury-Jones, 2007; Guillemin and Gillam, 2004; Pillow, 2003; Stronach *et al.*, 2007). Reflexivity involves turning the researcher's lens onto myself while acknowledging, recognising and taking responsibility of my situatedness within the research and how it may affect the setting, people being studied, questions being asked, data being collected and its interpretation. As such, the idea of reflexivity challenges the view of knowledge production as independent of the researcher producing it, and of knowledge as objective.

My primary observation at the start of this doctoral journey was that as this programme was funded by my NHS organisation to improve and progress evidence-based practice in the service, it might impose challenges and influences around my position as an independent researcher. Certain influences were related to the research outcome and the interests of the organisation. I was aware of these influences from the start and remaining reflexive and reflective throughout the research has helped me maintain rigour. I kept a reflective diary (Appendix 6) that was written up immediately after each interview in order to best capture a true reflection of the events. My reflective diary and detailed account of the step-by-step systematic approach I have taken demonstrate a rigorous research process throughout, which is supported by Vicary *et al.* (2017). Appendix 6 contains an extract of the reflective diary that I kept during interpretation of the transcripts. For obvious reasons I have not included information or accounts that would breach participant confidentiality. In Chapter 5 and Appendix 6, I show how this reflective diary and additional notes (Appendix 7) taken during the interviews were useful in the interpretation of the transcripts.

Having previously worked as a ward manager I understood that complicated relationships occasionally crop up between managers and junior staff in clinical practice. This awareness was useful during the interviews, enabling me to accept the participants' experience sensitively, particularly if they expressed concerns regarding levels of support and evidence-based practices. I was aware that my personal and professional journey has influenced the choice of topic for this research. I was also informed by my many years working in areas of challenging behaviour; therefore, have approached this research with preconceptions. As a male immigrant from an ethnic minority group, I felt able to relate to many of my service users who are male, black, and perceived as violent and aggressive, hence often subjected to restrictive interventions. Many of my nursing colleagues are from a minority ethnic background who observe challenging behaviour and restrictive interventions from a cultural viewpoint, which I can also relate to. This resonance with my participants was

beneficial, as it provided a richer and more deeply informed understanding of their life-worlds and the experiences they recounted.

Throughout this doctoral programme, I have identified and remained close to some essential considerations, such as potential personal biases. As a clinician and a nurse consultant, I held sufficient authority and seniority to have impacted on the participants' responses. I have also identified that having remained close to PBS in clinical practice, and based on my experience of the intervention, I regarded it as a positive framework, which could have influenced my judgements rather than understanding it from my participants' viewpoint. I have demonstrated my interpretivist position throughout my journey as a healthcare professional who accepts that people's experiences cannot be evaluated objectively but must be carefully recorded and listened to. Therefore, while taking this approach, adopting a relativist ontological position, and constantly reminding myself 'the world may be different for you than it is for me', I accepted the existence and value of others' wide-ranging personal experiences. Throughout my academic involvement with doctoral peers, many discussions have taken place that influenced my approach to reducing potential biases. Through group discussions and reflective forums, I have gained deeper understanding of potential biases emanating from my professional role. As a result of numerous on-going discussions with my academic supervisors, and through reflective practices I committed to seeking out and reducing these biases.

As a trust employee, I felt privileged to have built successful rapports with the participants during this study; a relationship imperative to creating a comfortable environment in which they were willing to describe their experiences. I was always conscious of not allowing my manner of questioning or seeking clarification to be inappropriately influenced by my interest, position, and views of PBS. Equally, it felt important to reassure participants that my views would not influence theirs. Indeed, if I had to express a different view this would be done sensitively, in a way that did not diminish the participant's perspectives but sought out participant interpretations and impressions of that different opinion. This approach employed skills and qualities that I developed during nurse training and applied throughout eighteen years as a clinician, but also resulted from committing to the role of a reflexive researcher. This aspect is discussed in more detail as this section progresses.

This combination of having built a trusting connection together with interpersonal skills learned throughout my career not only ensured a smooth interview process but also offered participants the appropriate reassurances that their lived experiences were not under scrutiny

or judgement and nor was the research intended to criticise their practice. This was established by the participants' response (see 4.3, RNLD 12) confirming that they felt an atmosphere of security and safety during interviews by displaying openness, honesty, and transparency (Appendix 5). Moreover, in these meetings, I believed my experience, awareness, and interest in PBS proved valuable, because I was able to understand and contextualise the participants' narratives, which was an added benefit. However, I was mindful that my interpretation of the data did not interfere with or slant the participants' original intentions. This can be described as being aware of the powerful subjective influences that might otherwise have affected the research. I attained this level of awareness and objectivity by constantly bearing in mind my views, position, and experience of PBS, but also acknowledging that they were not necessarily ones that others need to accept, so acknowledging in concrete terms that each participant may hold different and unique viewpoints.

Specifically, my personal experience of violence and aggression was crucially important. As an observer of aggression in a particular context, I have first-hand experience of such manifestations. While the context of aggression from personal experience may be different from in a hospital setting, I have nevertheless taken a journey of self-discovery concerning my ability to cope with difficult situations. The cultural background where I was brought up and which, in adulthood, has enriched my understanding of the physical, psychological, and emotional impact of hostility on individuals contributed useful lessons. Circumstances have certainly shaped my perception, views and attitudes towards violence and destructive behaviours and therefore help in understanding the participants' experience of it. My personality as an introvert, characterised by ongoing reflective and self-awareness processes, has no doubt been pivotal in developing my consciousness and coping strategies regarding challenging situations; they been the subject of constant reflection, analysis, and internal evaluation. I was guided towards Finlay (2002a, 2002b) who argues for the importance of introspection and self-analysis for bringing rigour and credibility to qualitative research. This awareness was a fundamental requirement during the interview process as it facilitated self-control, knowing when to stop, and how far to take the participants on the path of their own experiences, flexibility, and sensitivity in prompting interviewees. The careful yet constant self-questioning and self-interrogating exercises that I undertook throughout have helped me fully appreciate the participants' experience as closely as possible to how they wanted it to be understood. Indeed, qualitative research requires a healthy blend of interaction between the researcher and participants (McCabe and Holmes, 2009); therefore, I

was duty-bound in my role as a researcher to minimise potential bias, so the stories remained those of the participants and not mine.

Reflexivity plays an important role in qualitative research (Finlay, 2002b, 2003; Lambert *et al.*, 2010). I was attentive and reflective over my knowledge, values, philosophy, principles, background, and social milieu, in a way that assisted me to shape the research procedure (Creswell, 2013). Having worked in challenging environments for most of my nursing career, I was able to draw on my professional and clinical experience of violence and aggression, and the impact that these have on individuals, their families and health professionals. I reminded myself of how as a nurse, and later as a nurse manager, I have received support and supported colleagues during difficult times, especially after episodes of violence, aggression, physical restraint, and seclusion. I utilised this background to ensure that participants were understood, safe and supported during interviews, so creating an opportunity for me to define my standpoint within this research, grounded in the interpretivist paradigm, and to my being able to utilise this awareness towards progression, as discussed in Underwood *et al.* (2010). Similarly, I remained fully cognisant that I have used PBS in practice, indeed introduced the intervention on a ward I managed. This could be my bias towards the PBS framework. However, I was careful during interviews and data analysis to examine the participants' world and to acknowledge their truths as being authentic even if they voiced an opposite opinion. While I have witnessed PBS having helped change people's lives on the wards, I hold the view that PBS cannot be unwillingly imposed on anybody: the success of this practice is dependent on engagement and its acceptance. This is to say, I kept an impartial attitude on the implementation of PBS and the many barriers that may influence its application. This approach has ensured that I remained impartial, and that the study achieved rigour and quality.

Next, I took the approach to step back, analyse, review, reflect and contextualise the data received from my participants. This created another opportunity to appraise my position in this research, my personal views, interests, and experience of PBS.

Considerations that arose in my role as a student researcher referred to our professional code of conduct, when I often reminded staff of our duty of care and respect for our profession, employer, public and mainly service users. I was aware that the participants were work colleagues, and to some, I had been their line manager during their employment. This potentially could have impacted on participants' feelings and openness, particularly if they feel compelled to express positive views. I note, however, that the participants volunteered to participate, which shows their willingness to talk, and of course I was committed to maintain

their anonymity and confidentiality. However, participants were aware of my duty of care and that issues of any bad practices or safeguarding concerns would have been addressed. I made a mental reflective statement about my own beliefs, experience, and values regarding PBS, which I referred to throughout the research. Moreover, a reflective diary helped me during the interpretation process of this study. I was aware that participants' accounts would be influenced if they felt their competence and knowledge of PBS were being assessed. I clarified this and addressed the above points with the participating nurses beforehand (see 4.6.2), which offered me the opportunity to analyse the influence of such potential events during the research. I built on previous experience of ward management which involved discipline and performance manage of staff, while concurrently ensuring teamwork and professional relationships were maintained. This was indeed a challenging task, undertaken with reference to previous experience, using emotional intelligence and maintaining a positive awareness of self and others. Fortunately, during the interviews, as far as I am aware, this was not an issue that I needed to address openly.

A significant proportion of possible issues on data collection, confidentiality, respect, privacy and data storage were dealt with during the robust recruitment process, including clarifying the Participant Information Sheet (PIS-Appendix 8), constructing a screening process, and preparing the interview process (see 4.5.2).

An important aspect for consideration was an ability to constantly question, reflect and query the chosen methods and methodology, and to scrutinise how the findings could have been different in a different context (Palaganas *et al.*, 2017). This is commonly referred to as epistemological reflexivity (Goodall, 2016) (see 4.2).

4.5 Ethics considerations

4.5.1 Ethics approval

The NHS Research Ethics Committees (RECs) have an overarching duty to safeguard the interests of participants during research projects, especially following reports of abuse and lack of safeguard towards vulnerable individuals (Tallack, 2017). Schuklenk (2000) and Remenyi *et al*. (2011) have established that the ethical requirements for healthcare research must ensure that participants in health care services are not harmed or subjected to invasive trials. It is an imperative requirement to gain participants' informed consent before any research project. Dawson (2014) argues that one of the most significant qualities of a researcher is to be an ethical one. It was fundamental that participants were treated with respect and dignity during the study, all the way through the recruitment and interview

process. I was transparent and upfront with participants at all times, so that their voluntary participation was based on informed decisions and the right to withdraw at any time, including withdrawing interview data from the study after the event. Ethical considerations are exceptionally significant to any research, particularly in health care settings, as it safeguards the interest of individuals taking part who may be extremely vulnerable (Long and Johnson, 2007). Nurses were not considered intrinsically vulnerable but could equally become so during the interviews. Holding fast to the ethics of research is therefore imperative, irrespective of service users' involvement (Gregory, 2003; Oliver, 2010). These were some of the guiding principles that provided a congruent foundation for my study.

The project was granted ethical approval from the University of Salford and is registered with the Research and Development Department, and the Quality Assurance Department of my NHS trust. Appendix 9 evidences the ethical approval for this research. No other ethical approval was deemed necessary because it did not involve service users. It was not co-produced with service users as they did not form the central focus of this study; an aspect that is further discussed in section 2.6. However, from an ethical point of view, I followed and complied with relevant local NHS trust policies, protocols, and guidelines. I also read the Royal College of Nursing (RCN) Research Ethics: Guidance for Nurses (2011) and have fulfilled those requirements together with the principles of the Research Governance Framework (DH, 2005).

4.5.2 Informed consent

Every nurse who expressed an interest in this research was sent a consent form and a Participant Information Sheet (PIS) (Appendix 8). On the day of interview, I made sure the participant was fully aware of the aims and objectives of my research, how I valued their participation, and that their input was voluntary. In doing so, I gained the participants' informed consent to proceed with the interview. The PIS also contained the name of a trust director who they could contact if they had further questions, complaints, or queries about the study, or my if behaviour became a concern. The director was independent of my research but was aware of this study. Once I had read the PIS to the participants, followed by an opportunity for questions, the nurses were invited to sign the consent form (Appendix 10). However, they were advised that they could withdraw consent at any time during the process, without having to justify or explain their withdrawal, and if data had been collected this would be destroyed immediately.

Before signing the consent form, participants were informed that the interviews would form part of my thesis. However, reassurance was given that they would not be identified by

name or other identifiable data, but their narratives would be included as quotes in the thesis. An explanation was given that they would be allocated a unique code that anonymised their personal information, in line with information governance protocols and the General Data Protection Regulations (GDPR) in place within the organisation, and ethics requirements. Participants were further advised that, besides using a recording device, I would take additional notes as and when required during the interviews, but that they were only to support my reflection during the process and during data analysis. I also explained that I might need to conduct more than one interview, but this would only take place if they agreed. Finally, participants were informed that, if they wished, the outcome of the study would be summarised and sent to them individually either by email or, if they preferred, through an individual feedback session. Another discussion was around the publication of papers in academic journals for wider dissemination (see 7.6).

4.5.3 Risk assessment

According to Long and Johnson (2007), a risk assessment is recommended before a research project as part of the ethics approval process. In my study, it was carried out to ensure measures were in place so that any risks to the participants were identified and managed promptly (Long and Johnson, 2007). My extensive clinical experience made me competent at identifying signs of distress, or situations where people could be at risk of becoming stressed during interview. An independent clinician was requested to be available, to offer support to any participants who needed it. I also offered free and confidential support service opportunities to the participants through the trust's occupational health team. However, to the best of my knowledge, no risk was identified and the need to provide further support to the participants was not required. Nevertheless, specific concerns were present concerning infection prevention and control, due to the concurrent Covid-19 pandemic. During face-to-face interviews amid the Covid-19 pandemic I put correct measures in place to protect everybody, compliant with national guidelines and trust protocols.

4.5.4 Transparency

Structures were put in place to ensure every step and process during this research was transparent. As I work for the NHS Trust where the study took place and might be known to the participants, every aspect of this study was based on principles of honesty and trustworthiness (Shaw, 2010; Israel, 2015). To reassure participants of confidentiality and respect, I devised the PIS stating non-disclosure of our discussions and that no data was to be released, including to service managers or Director of Services. I was mindful that there

could be a power imbalance between my position as a researcher and a senior staff member, and the participants being colleagues and less senior co-workers. This issue was addressed through the ethical approval process by adopting an honest approach to the research project, and by informing participants that the study was independent of my clinical role within the organisation. It was imperative that this issue was acknowledged with due seriousness, and it was my duty to engage with the participants as a researcher rather than as manager (Bryman, 1992; Palaganas *et al.*, 2017). Nurses involved were advised that my role was purely for research purposes. Additionally, the interpretative nature of the study meant any power dynamics which might have influenced the participants' narratives would be addressed by making participants equal stakeholders. This was accomplished by being aware of any power imbalance that may exist, keeping a reflective diary and referring to my own beliefs, values and position within this research and, notably, by giving the participants a platform where they felt valued, had a story to tell and their narratives were respected. This approach ensured the power imbalance was addressed and that participants felt comfortable sharing their experience of PBS.

4.5.5 Confidentiality

One primary priority was to ensure participants were treated with respect and dignity, particularly at the interviews (Elger, 2016; Miller *et al.*, 2012). This research involved registered nurses who may have wished to disclose experiences of a distressing nature, so the environment and rapport with participants needed to encourage an open discussion. I was cognisant that participants might express personal or critical views which they may wish to keep confidential. As a researcher, bound by ethics, I have fully respected this.

Reliability and trustworthiness are major qualities that a researcher needs to demonstrate in any research process (Morse *et al.*, 2002). Trustworthiness has several elements attached to it, such as credibility, fit, and the presence of an audit trail (Guba and Lincoln, 1981). To maintain reliability and trustworthiness at the data collection stage, analysis, and in the research in general, I ensured there was an audit trail in place through the NVivo QDAS tool. Morse *et al*. (2002) proposed that simply being able to demonstrate decision points in a project via an audit trail, provided reassurance about the quality of the decisions. This was further reinforced by being reflexive throughout the research journey as discussed in section 4.4. I have also respected the participants' wishes not to have full transcripts included in this thesis.

4.6 Sample size

In hermeneutic phenomenology research, a sample size of between 5–25 is often deemed adequate to achieve rich and in-depth data from the interviews (Creswell, 2013; Green and Thorogood, 2014). Vasileiou *et al.* (2018) argue that in qualitative research where phenomenology is applied, sample size is determined by the emergence of no new themes, therefore the number cannot be set in advance. According to Morse (2015, p.587) saturation in phenomenological studies is attained when the understanding of the 'phenomenon becomes stronger, more evident, more consistent, more comprehensive and more mature', therefore this does not depend on a formula or a pre-determined size.

It is argued that sample size in qualitative research cannot be agreed beforehand (Liamputtong, 2009; Sim *et al.*, 2018), but Bagnasco *et al*. (2014) have suggested that, as an indication, any number between 5–25 participants is enough in phenomenological studies where the aim is to gain a rich set of data rather than focusing on a number. While considering sample size, it is necessary to be aware of the extent of the data being sought, and of the interview process. Patton (2002) and Bryman (2012) have argued that in hermeneutic phenomenology the sample size tends to be small because data analysis is more extensive. This is echoed by Polit and Beck (2012) who posit that in phenomenological studies, sample size tends to be around 10 or less. The recruitment of small sample sizes is further supported by other studies as identified by my literature review (Karger *et al.*, 2018, recruited 11 participants; Davies *et al.*, 2016, recruited 10 participants and Perez *et al*., 2012, recruited 10 participants). However, it was evident from the literature review that a sample of at least 6 was deemed appropriate to evaluate the PBS experience of individuals. While different authors have tried to address the issue of sample size in qualitative research, and specifically in phenomenology, the overarching argument is that no definite size can be agreed upon as this is dependent on the quality and richness of the data (Vasileiou *et al.*, 2018).

However, van Manen *et al.* (2016) posit that phenomenological understanding is not about filling up a qualitative container until it is full, neither is it about digging a data site of meaning until there is nothing else left to unearth. This refers to the concept of saturation in qualitative studies, mainly in grounded, theory where Boyd (2001) observes that 2–10 participants are enough to reach the saturation of data. I share the view that in hermeneutic phenomenology the emphasis is on understanding and interpretation of the lived experience and the process of interpretation is a never-ending process meaning that saturation, as it is often described, is not necessarily achieved in the same way in each project.

Lichtman (2006) asserts that the tenets of hermeneutic phenomenology offer the researcher flexibility to make their own judgement on sample size, and when contemplating sample size, emphasis is on the number of participants who have the relevant experience and ensuring that they can voice their particular experience in the manner they wish (Merriam, 2009; Denzin and Lincoln, 2013). By using a purposive sample of registered nurses who are PBS trained, my research has satisfied this test of hermeneutic phenomenology. Dibley *et al.* (2020) provide further authority regarding sample size in hermeneutic phenomenology by suggesting that a larger sample size only provides a set of more shallow data compared to the smaller size. Indeed, Sanders (1982, p.356) points out that, 'more subjects do not yield more information'.

Whilst Creswell (1998: p.65 and p.113) recommends 'interviews with up to 10 people' for a phenomenological study, Sanders (1982) believes it is realistic to expect that 3–6 individuals provide sufficient information and argues that 'quality should not be confused with quantity' (p.356). Therefore, it became evident that my sample, supported by the methodology, evidence, my sample framework (Figure 1) and literature review, did not have to be large, but a range between 6 and 20 participants were more than enough to satisfy a phenomenological enquiry and harvest a rich data set.

4.6.1 Inclusion and exclusion criteria

Inclusion and exclusion criteria set during the recruitment process are shown in Table 2. To recruit participants, there was trust-wide communication (Appendix 11).

Participants	**Inclusion criteria**	**Exclusion criteria**
Nurses	Nurses on the NMC (Nursing and Midwifery Council) register Nurses who have used PBS in practice or who have had any form of PBS training Nurses who have been involved in the delivery of PBS in mental health or learning disability services either with in-patients or in the community Participants employed by the NHS organisation (in any capacity) Those who voluntarily give consent to participate in this study, have signed a consent form and read the PIS.	Nurses in pre-registration training and other trainees such as student nurses, trainee nursing associates Nurses not aware of PBS Retired nurses and those who have left the trust. Agency staff who work on a bank basis Nurses who have not used PBS or have no training on PBS.

Table 2: An overview of the participants' inclusion and exclusion parameters.

The study used purposeful sampling, explained by Patton (2002) as a widely used technique in qualitative research for the appropriate identification and selection of participants that might provide rich information. This technique involves identifying and selecting participants, or groups of participants, who are especially knowledgeable about or experienced in the subject being studied (Creswell and Plano Clark, 2011). In this case, purposeful sampling consisted of registered nurses with PBS experience, and excluded all health workers who were not registered under the NMC. This criterion excluded other staff such as health care assistants, support workers, nursing associates, and student nurses. This was because, as a registered nurse, the individual is bound by the NMC code of conduct, implying greater accountability and responsibility in managing care and overseeing the implementation of PBS. Registered nurses are also regularly at the frontline of care delivery, taking responsibility for PBS and leading a team, while making difficult and important decisions in the care of service users who have behaviours of concern. It was my view that this puts nurses in a unique position in the context of PBS and challenging behaviour. Significantly, there is a gap in the literature regarding nurses' experience of PBS as a unilateral group. I excluded agency staff who work on bank basis as they were not routinely offered BILD or in-house PBS training.

4.6.2 Recruitment

The study site is an NHS organisation that provides integrated mental health and physical health services to three boroughs in London. This study was funded by the NHS trust that employs over 3,000 staff in about 20 locations providing community care, in-patient mental health, and learning disability services. There are 29 in-patient wards within the organisation, delivering services in various settings. Services include forensics, eating disorders, psychiatric intensive care (PICU), acute mental health (MH) and learning disability (LD) services. The trust provides crisis intervention, older adult services, and children & adolescent mental health services (CAMHS) too. It employs around 3000 staff, of which 950 are registered nurses.

The study was approved to be carried out by an NHS Research Ethics committee, University of Salford (3rd August 2017- HSR1617-126). Once I received ethics clearance, authorisation was sought from the director of the organisation, and relevant senior managers at the NHS trust were advised of the recruitment process. The study was registered with the trust research and development department to satisfy internal transparency. Appropriate communication (Appendix 11) was sent on my behalf to managers to advise them of the study and asking them to act as first point of contact for potential volunteers. There was a

systematic approach to the recruitment of participants through a predetermined process. A step-by-step approach was useful so that staff did not feel obliged to participate – this also meant that I was not aware of who may have declined participation. The process involved managers as gatekeepers who were tasked to compile names and provide a synopsis of the study together with a copy of the PIS. The managers were advised to signpost interested staff to me, who were then given opportunities to ask any questions and to complete a form (Appendix 12) that assessed their suitability to partake in the study. I called this step the screening process. I discussed participation in much more detail when answering the volunteers' questions and followed that up with a formal letter of invitation (Appendix 13) to participate in the project. It was noted that no nurse was found ineligible during screening. PIS and consent forms were further discussed and signed.

The recruitment of participants started before the Covid-19 pandemic and continued during it; this meant there were a few barriers to recruitment. One of these relates to registered nurses being extremely busy working on the frontline to support patients at this critical time, plus a high level of staff sickness and staff shielding. Every effort was made not to disrupt the natural process of care delivery in the organisation. Some adjustments were required due to the pandemic, particularly concerning flexibility of where to conduct interviews and provision of facilities for online or telephone interviews. I noted in my literature review that, in some studies, interviews were already being conducted on Skype before the pandemic (see 3.6.4).

The trust did not hold a centralised training register because at the time of recruitment there was no sustainable and consistent PBS training. Therefore, data on PBS training was received from the head of psychological therapies who organised the BILD training. The chart below shows a sampling framework illustrating where my sample was drawn from. Therefore, within my sampling framework for this study there were a possible 50 participants. Figure 2 (below) provides an overview of services provided by the NHS trust and the sample framework (Given, 2008).

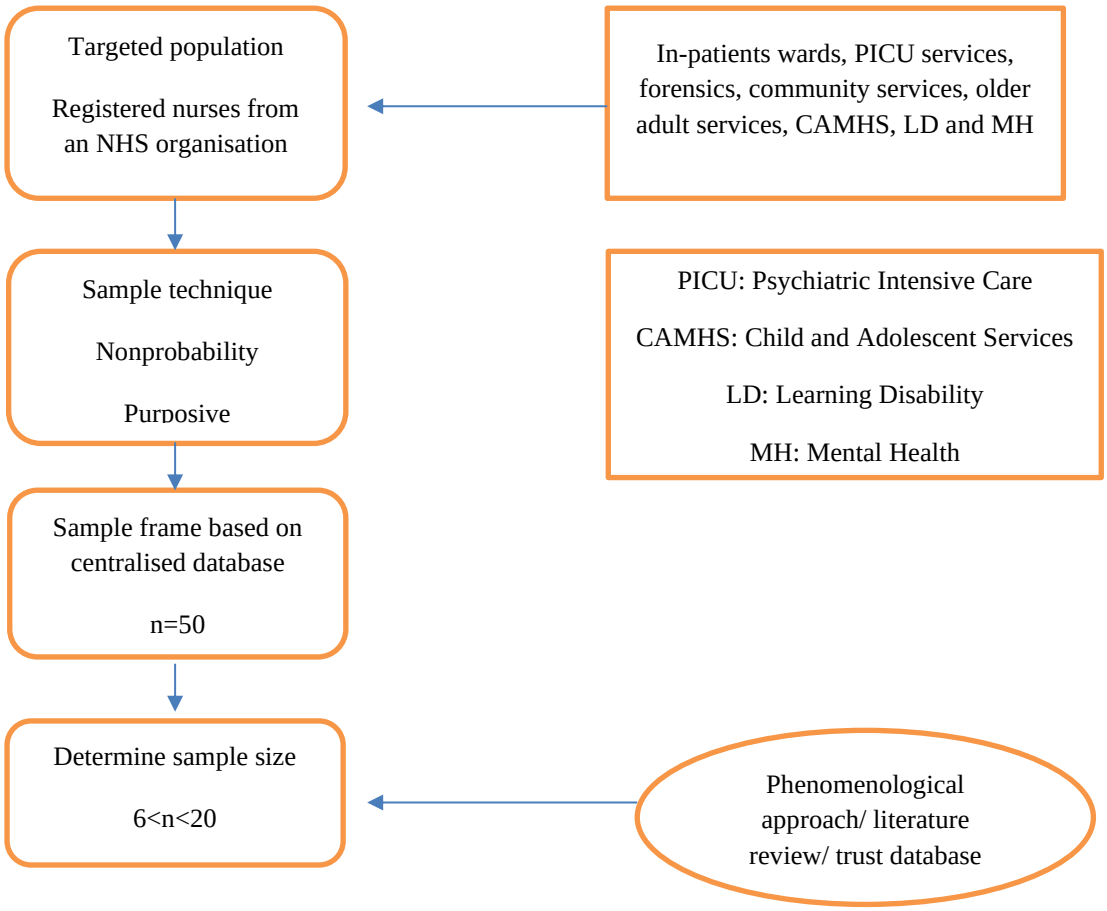

Fig. 2: sample framework

4.6.3 Participants

My participants comprised both mental health and learning disability registered nurses (distinguished by the acronyms RMN or RNLD), who, as established by the selection criteria, had PBS experience and/or training and who satisfied the inclusion and exclusion criteria (Table 2, see 4.6.1). There was a systematic approach to advertising for, and to recruitment and screening of participants. A total of 19 participants volunteered and were found suitable to take part in this study. These individuals were approached through the internal communication during recruitment as detailed above.

4.6.4 Participants' characteristics

To maintain participants' confidentiality, no identifiable information was disclosed such as age, place of work or any information that may reveal their identity. Instead, each participant was given a code (RMN or RNLD, 1, 2, 3, 4 etc.), indicating whether the nurse was mental health (RMN) or learning disability (RNLD) registered. This distinction was important during data analysis in case anything required further exploration from an RMN or RNLD perspective. The display of non-identifying information is in line with the GDPR regulations. Table 3 presents some of the participants' characteristics.

Participants	Gender	Length of service	PBS Experience/Training	Interview
RMN 1	Male	10 years	In-house PBS awareness training. 5 years' experience of PBS	Face-to-face
RMN 2	Male	6 years	In-house PBS awareness training. 4 years' experience of PBS	Face-to-face
RMN 3	Female	3 years	In-house PBS awareness training. 2 years' experience of PBS	Face-to-face
RMN 4	Female	5 years	In-house PBS awareness training. 3 years' experience of PBS	Face-to-face
RNLD 5	Female	2 years	Pre-registration and in-house PBS awareness training. 2 years' experience of PBS	Face-to-face
RNLD 6	Female	10 years	Pre-registration and in-house PBS awareness training. 5 years' experience of PBS	Face-to-face
RNLD 7	Female	2 years	Pre-registration and in-house PBS awareness training. 2 years' experience of PBS	MS Teams
RMN 8	Female	16 years	In-house PBS awareness training. 4 years' experience of PBS	Face-to-face (wearing mask)
RMN 9	Female	7 years	In-house PBS awareness training. 5 years' experience of PBS	MS Teams

RNLD 10	Female	5 years	Pre-registration and in-house PBS awareness training. 2 years of PBS use	MS Teams
RNLD 11	Female	3 years	Pre-registration, BILD and in-house PBS awareness training. 2 years' experience of PBS	Face-to-face (wearing mask)
RNLD 12	Male	6 years	Pre-registration and in-house PBS awareness training. 4 years' experience of PBS	Face-to-face (wearing mask)
RMN 13	Female	6 years	In-house PBS awareness training and BILD training. 5 years' experience of PBS	MS Teams
RMN 14	Male	17 years	In-house PBS awareness training. 5 years' experience of PBS	MS Teams
RMN 15	Female	19 years	In-house PBS awareness training. 5 years' experience of PBS	MS Teams
RMN 16	Female	10 years	In-house PBS awareness training. 2 years' experience of PBS	MS Teams
RMN 17	Male	14 years	In-house PBS awareness training and BILD training. 3 years' experience of PBS	MS Teams
RNLD 18	Female	4 years	In-house PBS awareness training and BILD training. 3 years' experience of PBS	MS Teams
RNLD 19	Female	19 years	In-house PBS awareness training and BILD training, 10 years' experience of PBS	MS Teams

Table 3: Participants' characteristics.

4.7 Data collection and preliminary analysis

Data was collected through semi-structured interviews. Once data was collected from the participants it was analysed using Thematic Analysis (TA) which, in keeping with hermeneutic phenomenology, involved an inductive approach. This means that the themes emerging from the research are true reflections of the participants' views and there was no attempt to fit the data to any pre-existing theory or hypothesis (Braun and Clarke, 2006; Ho *et al.*, 2017). The interviews lasted a maximum of one hour and were recorded using an audio recording device that facilitated transcription. Due to the Covid-19 pandemic, social distancing rules, and restrictions within the health organisation (Table 4), a few participants were interviewed via MS Teams (Table 3). The transcripts of those interviews were then uploaded onto NVivo (version 11) software for analysis. One advantage of using an audio recording device was that it facilitated a smooth interview process without the need to take a large volume of written notes even though participants had consented for me to take notes for future follow up or further exploration. Some additional notes were especially useful in capturing unspoken expressions, such as body language and facial expressions, which contributed towards understanding the narratives. The notes I took (Appendix 7) were equally beneficial for my reflective diary (Appendix 6), which in turn helped me identify and better understand the participants' experiences. It was challenging to arrange interviews in the current climate of staff shortage, but it was to be anticipated so I was flexible in providing as many alternative times and dates as possible. During the interviews, my prior knowledge of PBS proved significant for exploring the stories as told by the participants; a process that ensured all aspects of their accounts were valued, investigated, and understood. The participants sometimes used terminologies to describe their feelings and experience that may not have expressed their exact meaning; at times their meaning was a little ambiguous, when clarity and precision were required. By untangling occasional issues as necessary, I achieved clearer insights and understood the deeper meaning of the participants' accounts which provided a profound analysis.

The next step of the process involved transcribing the recorded interviews verbatim, reading and re-reading the transcripts, and classifying the notes in codes.

4.7.1 Handling data using NVivo

Over the years, computer-based qualitative data analysis software (QDAS) has helped many researchers in their qualitative studies (Malone and Coyne, 2017), and it continues to gain popularity, primarily because of its efficacy (Foley and Timonen, 2015). Moreover,

QDAS averts the need for hard copy files and drawers and helps reduce the manual tasks researchers would otherwise need to do, thereby leaving precious time for data analysis. Despite the well-documented benefits of computer software, there remain reservations and some reluctance to use this facility (Houghton *et al.*, 2017). So, discussion and debates on the benefits and disadvantages of using QDAS, especially in qualitative research are ongoing (Bergin, 2011).

QDAS is often criticised for bringing a quantitative dimension to qualitative research (Bazeley, 2007). Additionally, computer software is often associated with a large quantity of data, which means that quantity of data becomes a seemingly essential factor (Carroll *et al.*, 2013). However, Seidel (1991) argues that a large amount of data does not give the researcher the required depth of analysis because the focus remains on breadth. Therefore, computer software remains an appropriate tool for qualitative research, even with a small amount of data (Seidel, 1991), although in this study it was utilised solely for data storage and manual coding. Another criticism of QDAS is that the researcher may be viewed as distancing themself from the data, thus running the risk of the essential qualitative aspect being watered down. Therefore, researchers are advised to be mindful of this possibility (Cope, 2014; McLafferty and Farley, 2006). Gibbs (2004) argues that it is not the software but the researcher who interprets the data. When these arguments were analysed and put into perspective, considering my epistemological position, I formed the view that computer software could bring a few benefits to this study, particularly in storage, handling, and organisation of the data. During data analysis the 'auto-coding' function of NVivo was not used, rather the transcripts were manually coded, which guaranteed that I remained close to the data.

NVivo provided several practical benefits during data analysis as described above. The software was used as a storage system where the transcripts, data, codes, and themes were safely collected and were easily accessible during analysis. The software was also helpful in organising the transcripts to help with manual coding. The QDAS further assisted in maintaining memos and reflective diaries throughout the research process. NVivo provided a platform that allowed robustness, rigour, and thoroughness during data analysis. It offered the possibility to categorise themes in a way that made analysis both convenient and efficient.

4.8 Data analysis

The data that I audio-recorded was transcribed manually detailing a verbatim account of the interviews, then examined for emerging themes. The exact word-for-word interview

transcript was essential, along with my supporting notes. The analysis was done during Thematic Analysis (TA), which comprises six stages as set out by Braun and Clarke (2006). These are:

- Data Familiarisation
- Generating Initial Codes
- Searching for Themes
- Reviewing Themes
- Defining and Naming Themes
- Producing the Report

The thematic process involved producing a list of what transpired from the transcripts followed by the formation of codes (or Nodes as known in NVivo software). Although Braun and Clarke (2006) provide a set of six steps, they make provision for flexibility of use by researchers. The coding exercise was ongoing, and the outcomes were saved on the computer software for future analysis.

4.9. Thematic analysis (TA)

TA is a commonly used qualitative method that serves to recognise report and examine data originating from people, situations, and events (Aronson, 1994; Boyatzis, 1998; Braun and Clarke, 2006; Patton, 2002; Riessman, 2008). Due to the flexibility that it offers, TA is considered valuable in different research areas including social sciences, physical sciences, medicine, psychotherapy, and mathematics (Mortl and Gelo, 2015; Clarke and Braun, 2018). In this study, TA was the preferred method for data analysis due to the abundance of literature advocating its suitability, versatility, and its wide utilisation as a method to analyse and report on themes (Boyatzis, 1998; Patton, 2002; Braun and Clarke, 2006). TA was the most appropriate fit that complemented hermeneutic phenomenology as a methodology as it provided a structured approach in the different stages of interpreting the transcripts. This method was favoured due to its usefulness in offering a framework in which to explore lived experience, where it facilitates my movements to and from each of the six stages of the process (van Manen, 2014; Ho *et al.*, 2017).

In TA there are two ways of gathering data and coding (Braun and Clarke, 2006; 2017). One is inductive while the other is a theoretical (or deductive) process. The inductive process tends to suggest that themes are intensively linked to the data, unlike the deductive approach where the starting point is often a hypothesis that is tested; it is mostly utilised in

quantitative studies (Azungah, 2018). My position within the interpretivist paradigm favoured TA as the most appropriate method because it offered a degree of epistemological and methodological flexibility. Elliott and Jordan (2010) conclude that a purely inductive or deductive method in TA may not always be possible. Therefore, as a researcher using hermeneutic phenomenology for data analysis, I was aware that TA would be beneficial alongside my interpretation and experience of the subject matter during theme formation. My immersion in the data and pre-understanding were significant in the inductive approach.

It is proposed that, while there is significance to the frequency of a theme occurring, it is equally important that it derives from participants' consistency and uniformity in referring to that theme (Patton, 2002). Tuckett (2005) and Braun and Clarke (2006) assert that the consistency of themes requires a structured and methodological coding process to confirm its reliability. My ward management and PBS experience was fundamental during the hermeneutic process and thematic identification. Judging and deciding what 'became a theme' was extremely relevant; indeed, it was a crucial part of data analysis and was essentially influenced by my reflexive approach that helped maintain credibility, reliability, and validity.

Braun and Clarke (2006) and Tuckett (2005) propose that a key element in the coding process is the importance, relevance, and connection of the interview transcript to the research question. While coding is a time-consuming process, NVivo software became a useful tool because it eliminated the need for hard copies during data analysis. The software had functions that helped me group the sub-themes under the main themes. Regarding data analysis, I decided to undertake manual coding so that I remained close to the data, which is one of the key tenets of hermeneutic phenomenology.

The manual coding process involved highlighting parts and aspects of the transcripts then clicking 'analysis' on NVivo to assign that section to a node. The node was either already created or a completely new one. Edwards and Titchen (2003) recommend the formation of 'first-order constructs' and 'second-order constructs' during coding exercises (Appendix 14). First-order constructs in this context were the exact words uttered by the participants, comprising language and narratives, whereas second-order constructs were my interpretations developed from the first-order constructs (Ajjawi and Higgs, 2007).
It was essential to appreciate the hermeneutical approach as a continuous and recursive process, where part of the transcript is linked to the larger whole, but it was equally significant to understand the narratives in connection to their wider relationship with the participants. The six stages of TA are discussed below:

Stage 1: Data Familiarisation

One benefit of verbatim transcribing is that it allows a full discovery of the meaning of a specific phenomenon for each participant (Clarke and Braun, 2013). On NVivo, each transcript was read and re-read until the phenomenon central to the lived experience of each participant was fully understood. I found that reading printed transcripts was equally helpful, meaning I could access the notes anytime without having to log on NVivo. I took brief notes as the transcripts were read and re-read, in conjunction with reading the additional notes (Appendix 7) made at the time of interview, and my reflective diary (Appendix 6). This step-by-step exercise ensured familiarity with the texts. Van Manen (1997) identifies this as the 'immersion' stage of the process, wherein I became fully engrossed in the data. At this point I was fully engaged with the process of phenomenological reflection of asking crucial questions based on Heidegger's statement that 'We never come to thoughts. They come to us' (Heidegger, 1971, p 6). This stage helped me become familiar with the social reality of the phenomenon (Burrell and Morgan, 2017). After reading line-by-line, focusing on narratives/statements that enlightened the phenomenon, sections of text were assigned into possible codes. At this juncture I asked myself 'What is the data saying about the experience?' and 'What else might be going on?'. The relevant texts were then highlighted and recorded on NVivo software under a specific theme or themes. These became my initial thoughts. I repeated this process with each interview transcript until they were all were fully analysed. Excerpts of the transcripts became the first order construct: the themes were identified from the participants' comments and then analysed to make sense of the different experiences and viewpoints (Appendix 14).

Stage 2: Generating Initial Codes

This stage of generating initial codes (or emergent themes) is also referred to as abstraction and refers to the process of working through first-order constructs, interpretation notes and additional notes to then generate the emergent themes (Tables 4 and 5). This exercise leads to producing second-order constructs through the researcher's interpretation. I worked through the interpretation of each transcript before creating an individual interpretive summary. The process aided my understanding and interpretation of the transcripts while also deploying my background knowledge and experience of PBS. As I did so I became aware that it was possible to reach different interpretations; so, I aimed to ensure each interpretation remained true and relevant to the nurses' experience and to the existing literature by making constant reference to the additional notes and reflective journal. Towards the end of the

process, my intention was to group the texts into second-order constructs, sub-themes, and themes. This is further explained below.

Stage 3: Searching for Themes

After sub-themes had surfaced from the emergent themes, the process indicated that I return to the transcripts to conserve my closeness to the data. This exercise is fundamental, as it upholds the hermeneutic aspect during the appearance of themes. It also provided an opportunity to re-examine the data and identify any new layers of explanation that would be similar to or consistent with the participants' accounts. At the end of this stage, the transcripts were reread, and the full texts robustly and consistently analysed. It was after this point that the second-order constructs and sub themes emerged more clearly from the texts.

Stage 4: Reviewing Themes

The purpose of review was to check the themes against the codes in order to produce a thematic map for each one. Braun and Clarke (2006) refer to this phase as the highest level of hermeneutic analysis, where constitutive patterns emerge or patterns that communicate the relationships between different themes in the transcripts. At this point I reread the interview texts (Appendix 14) to obtain a comprehensive and holistic view of the nurses' narratives of PBS, drawing on my experience and knowledge of the framework as a resource alongside the literature review. My goal was to review potential themes to check the coded extracts relationship to existing evidence on PBS. As throughout the study, I was conscious of potential biases as a result of my interest in PBS, so I was careful to maintain a reflexive approach by keeping a non-judgemental attitude to the recorded views and reaffirming my interpretivist stance of accepting how people have divergent worldviews, and that my role was to understand the participants' perspectives. However, hermeneutic phenomenology does not recommend bracketing and, so, previous experience and knowledge are always at play as resources to be drawn upon. In this case, reflexivity and my epistemological position within this research were vital during the emergence and interpretation of themes. It remained essential to return to the outcomes of the PBS literature search (see 3.6.1), and to verify the issues already highlighted in the literature when making sense of the data and subsequent themes. The reviewing serves to interpret their meaning, while ensuring that participants' own experiences of PBS were not being diluted.

Stage 5: Defining and Naming Themes

At this point of the coding process several possible themes and sub-themes had become evident, so, along with refining the sub-themes, I began to consider other potential evolving

themes. This step is an opportunity to revisit the original literature review findings and correlate my interpretations alongside current PBS literature. To establish credibility, my interpretation went through a process of evaluation within the framework of phenomenological research. I referred to Madison (1988) and van Manen (2016), who claim that the rigour and quality of phenomenological research can be greatly improved if the researcher engages in an ongoing questioning attitude to identify any misinterpretations. I, therefore, aimed to embrace an interrogative approach, considering both the outcomes of the literature review and my experience of PBS. Appendix 14 illustrates an example of how the manual coding process took place during data analysis and shows the first-order construct, second-order construct (interpretation notes), emergent themes, sub-themes, and themes. Throughout, I discussed the transcripts with my academic supervisors and explored my interpretive approach to analysing the data, at the same time recognising that the interpretation of the transcripts is based on the researcher's prior understanding of the phenomenon being studied. This reinforced the concept that the interpretation is unique to the person undertaking the study, their background, knowledge, and awareness of the topic. It is therefore for the researcher to embark on a systematic and robust process where all materials, in this case my reflective diary and interviews notes, are employed to reach a conclusion. By this stage, particularly in hermeneutic phenomenology, any independent verification ensures the step by step procedure of interpretation is undertaken systematically and vigorously rather than the researcher comparing their interpretation with someone else's (Zimmermann, 2015).

Stage 6: Producing the Report

Collating the report provides a final opportunity to examine themes and identify their relationships to the interview transcripts by revisiting the extracts of the transcripts that became codes. This assists in developing sub-themes through the interpretation of the narratives. I aimed to consolidate my study of the emergence of different second-order constructs, sub-themes and themes and double-check that the merging of themes and their definitions congruently reflected the nurses' experience. The next step was to be the analysis of the themes as detailed in Chapter 5.

During analysis I maintained both a reflexive and unbiased approach to processing the individual data presented by each of my participants. This was to ensure rigour and integrity concerning my position, beliefs, values, background, and interests as reflected in the study. My reflective diary provided a platform for the ongoing mindfulness that guided my actions and thought processes. A reflective and reflexive standpoint, together with ongoing

supportive supervision, ensured that I did not only ask questions, but I was also receptive to the queries and interrogations arising from the texts as I interpreted the transcripts – a practice central to my interpretivist position. My set of beliefs, values and experience of PBS are essential components during interpretation of the data for contextualising and for deeper analysis of the data, but they were not allowed to become a source of bias that could deflect from a participant's opinion or story.

Spence (2017) has argued that robust hermeneutic phenomenology research requires the researcher to be open and ready to embark on a journey of examination, interrogation, and enquiry. I aimed to achieve this through adopting a practice of self-assessment, an ongoing review of my interest, values, and experience.

4.9.1 Conclusion

This chapter has explained the rationale for using hermeneutic phenomenology in this research, as opposed to other possible qualitative frameworks and methodologies. Methodologies such as GT, Charmaz's GT, and ethnography (Holloway and Galvin, 2016) were considered but, following careful analysis and reference to my literature review, a decision was made to exclude these based on the specific aims of the research. In section 4.2.1 there was an in-depth rationale for such a decision. This section has further explained the use of purposive sample and inductive approach, the choice of semi-structured interviews, and the choice of manual coding and TA supported by software, TA as per Braun and Clarke (2006), and its relevance to this study in analysing data. The rationale and use of QDAS NVivo (version 11), as a tool to aid data analysis, was explored. The sample size, participant selection process, and the process that I undertook towards generating second-order constructs, sub-themes and themes have also been discussed alongside appropriate ethical considerations, my role as a researcher, and the part that reflexivity has played during the research process. The next chapter explores the findings and analysis of this study.

5.0 Analysis and Findings

5.1 Introduction to chapter

This chapter provides a detailed account of the findings from my research topic, which explored nurses' PBS experience. Throughout this study I undertook a trustworthy approach, underpinned by my professional and personal experience of PBS, and using a reflexive process. In this chapter I bring together the experiences of 19 participants through an interpretative process discussed in the preceding chapter. I have included direct quotes from the interview transcripts (first construct) together with my interpretation (second construct), sub-themes, and themes. I showcase the step by step process employed to interpret the transcripts. In support of this, I have used RMN 9 as an example in this section to demonstrate my systematic approach which also protected high levels of reliability during my interpretation of the transcripts. Through the experience and transcripts of RMN 9, I illustrate how I have engaged in an intense hermeneutic and phenomenological exercise. In determining which transcript to use as an example I looked at the overall content of the data and its quality and chose RMN 9 who provided a rich set of data that offers a good illustration. While it has not been possible to include all the quotes in this chapter, a list of other participants' experiences can be found in Appendix 14.

5.2 Analysis

Here, I demonstrate the interpretation process through a thread starting from the participants' quotes and leading through to interpretation notes, emergent themes, the sub-themes, and themes. The interpretative approach follows a hermeneutic process that allows a systematic interpretation of the themes; analysis was performed in a flexible, consistent, yet thorough manner. The experience of 19 registered nurses is presented as the first construct; the second construct shows my interpretation of those experiences (interpretation notes); this led to the emergent themes (or domain summary as known in thematic analysis), sub-themes; and finally, to the themes.

5.2.1 Interpretation of the transcripts

In this section I have used participant RMN 9 as an example to demonstrate my strategy throughout the interpretation process, from first constructs to the development of themes. Each transcript went through the same process. In Table 4 and Appendix 14, I show the method embarked on when interpreting RMN 9's experience and include my interpretation notes to illustrate my thinking process. My reflective diary and additional notes supported me during

this process (Appendices 6 and 7), which involved a hermeneutic and phenomenological exercise of reading the transcripts, moving between different sections of the transcripts, and summarising my interpretations. Below is an excerpt from my reflective diary:

'I have recognised that I entered this first interview with some potential preconceived ideas such as the effectiveness of PBS and my interest in the topic. However, at the interview, I wrote down my position regarding PBS and I referred to this throughout so that I do not let this standpoint influence my questioning. I have made attempts to remain reflexive as my participants' account was more important than mine on this occasion – and I have constantly reminded myself that my study aims to capture what other people think, feel about PBS. By taking a position that multiples truths/realities exist, I have listened to the participant's voice. I have managed any potential bias. This is why I wanted to interact and record/transcribe the interviews verbatim.'

The additional notes I took during interviews (Appendix 7) were useful to refresh my mind about my thinking process during the conversations. For instance, in Appendix 7, I wrote down some key points that I thought of when RMN 9 talked about her experience of PBS. These concerned the role of nurses, PBS as a tool, factors affecting PBS implementation from her perspective, and the values element of PBS. My thinking at the time of interview was about teamworking, hierarchy, and practice leaders. These notes helped me during the interpretation of the whole transcripts, which was the same process for all 19 participants.

Transcripts (RMN 9)	Interpretation notes
'Nurses were quite involved in bringing ideas together, but it would have been much better if all of us had some formal training on PBS.'	Nurses can contribute towards PBS implementation and they identify equal access to structured training as essential.
'I think it was going by what has been said rather than we doing this because of, like, giving us more in-depth knowledge in the sense of why and what PBS is.' *'Why we are doing it and what is the difference…'*	First-hand information and knowledge from reliable source that depicts PBS as a practical and scientific framework is much welcomed It is not enough to just satisfy curiosity (or be acquainted) of what PBS is all about. Nurses need more knowledge.
'This situation would put nurses at the level where there would be no argument because everybody would be at the same level with regard to knowledge, competence and skills.' *There's also the idea of mentoring and supervision whereby junior nurses could be supervised using PBS in practice.*'	PBS training opportunities can potentially help nurses in an MDT context where everybody shares knowledge and competence equally. A supportive process or system can be helpful in coaching/mentoring those in needs towards their professional/personal development in PBS.
'So, I am not giving excuses, but these are the reality of the current situation and to be honest even without the Covid-19 pandemic we already had issues around resources, specially registered nurses, and this wasn't only a local issue but a nationwide problem.' *'And I would want to see everybody contributing to the model rather than having one discipline leading its implementation.'* *'Also making sure that nurses are working in collaboration with everybody else including psychologists and medical doctors so that there is a full MDT approach to the implementation of the framework.'*	Several factors affect the delivery of PBS; one of which is having the staff who are accountable and ready to make a difference A concerted effort towards PBS is welcomed. This gives nurses the status that they deserve, considering their therapeutic relationship/rapport with service users and others. There is the appreciation and recognition that nurses and others need to work as a team in the delivery of PBS and no single discipline can achieve this on their own.

'It could also consist of a mini diary that reflects what needs to be done… the type of thing that people would want to do.' *'So, to a certain degree it works but the difficulty that we had was consistency, or a lack of consistency, because staff were not following the plan.'*	The idea of reflective practice and the use of a reflective journal/diary that would help nurses to improve PBS practice. A clear and systematic approach was lacking in the delivery of PBS as staff were not working together instead it was more of working in silos.
'I think credit to them [clinical psychologists] they have done some research around it and they know a lot more about the model, so they know why they are doing what they are doing – and we don't.' *'What are you doing to challenge if you do not know how it works and you do not have the knowledge behind you?'* *'I think anxiety and fear around the unknown is something that needs to be addressed.'*	PBS is not the issue as it is recognised as a useful framework, the issue is more about human factors such as a lack of communication between staff. RMN 9 feels that clinical psychologists have the preparation, education and have done the research on PBS for them to be PBS practice leaders. A lack of empowerment and confidence from some nurses has contributed towards clinical psychologists taking a leading position in the field of PBS. Psychologists are familiar with PBS and therefore comfortable with the intervention compared to nurses.
'On the ward there was a lot of issues and tension around drugs use, so staff would often end up involved in physical restraint, seclusion and other restrictive intervention.' *'Currently Covid-19 has changed the ward environment so patients are facing a lot more restrictive intervention… therefore PBS could have been used to support these service users.'* *'But you just lose interest while you don't know the essence of why you're doing what you're doing.'* *'Traffic light system may not be tackling the problem – instead it could be a system whereby certain behaviours are deemed acceptable and others are not.'*	PBS framework and its principles have been successfully used in other areas of need. There is a clear understanding of how PBS can influence care in general and while doing so has due consideration to patients' safety. Patients have a right to be given all the support and care that they need and during the pandemic lockdown and restrictions on the wards, PBS could have served some benefits to the patients. The nurse wants to practice an intervention based on the knowledge underpinning it. Nurses remain aware of the importance of evidence-based practice in understanding behaviours. Like a reward chart, a traffic light system may find its place within PBS but that would create a perception that PBS is a behaviour modification strategy rather than a framework that helps understand patients' needs and improves quality of life.

'And it is supposed to be supporting the individual rather than being punitive or infringing on people's human rights.'	There is an understanding that the principle aim of PBS is to do with respecting the human rights of the individuals, albeit those whose behaviours are challenging.
'More about a team approach, and I would want to see everybody contributing to the model rather than having one discipline leading its implementation.' *'So, I would nominate somebody who would oversee the implementation… so that would be one thing that I would want to see in practice.'* *'A PBS plan also helped to bring back responsibility to the service user, because they would take ownership of their care.'* *'Also making sure that nurses are working in collaboration with everybody else including psychologists and medical doctors so that there is a full MDT approach to the implementation of the framework.'* *'Nurses have the background that could be useful in the implementation of PBS and psychologists would need to embrace that knowledge and work together.'*	To achieve a structured and multi-agency approach to PBS, there is a real need for leadership and commitment from experienced individuals. It is crucial that service users take the centre stage in PBS, as doing so may initiate the whole concept of consumer leadership in care. Nurses are tasked to ensure there is an MDT approach to PBS practice. This could be because of nurses' ability to ensure patients form part of the decision-making process. Nurses need recognition from others and appreciation for what they can contribute regarding PBS.
'It is supposed to be supporting the individual rather than being punitive or infringing on people's human rights.' *'PBS favours simplicity in the sense that the language that is used is clear simple and it identifies the behaviours that needs to be addressed and it also provides 'how' as much as the 'when' and 'by who.'* *'I think anxiety and fear around the unknown is something that needs to be addressed.'*	It is accepted that PBS is mainly about the ethical use of interventions to help patients with complex needs without using restrictive interventions as a first resort. PBS is effective when it is delivered in its simplest form without any sophistication. A clear and simple PBS plan will need to have the relevant information to help the patient and the many stakeholders supporting the patient. It can prevent escalation of certain behaviours. There is optimism that PBS could be useful in community services, although on-going discourse continues on the need for staff to know more about the model

'I accept that PBS could be useful in the community given the presentation of many of our service users.' *'Where does it come from and why it has to be implemented in such a way.'*	Nurses are still asking questions about PBS that remain to be answered in a clear and concise way. The unknown can be anxiety provoking for many nurses.

Table 4: RMN 9 transcripts.

5.2.2 Examples of developing emergent themes

In this section I show how the interpretation notes are analysed and developed into emergent themes (also known as domain summary in thematic analysis). Some of these emergent themes were presented as a simple question that I felt the participants were asking themselves when they spoke about their lived experience of PBS.

Interpretation notes	Emergent themes
Nurses can contribute towards PBS implementation and identify equal access to structured training as essential. First-hand information and knowledge from reliable source that depicts PBS as a practical framework is much welcomed. It is not enough to just satisfy curiosity about what PBS is all about. Nurses need more knowledge. PBS training opportunities can potentially help nurses in a MDT context where everybody share knowledge and competence equally. A supportive process or system can be helpful in coaching/mentoring those in need towards their professional/personal development in PBS.	Ability to ask for training. The need to be empowered. Comfortable within a system. Supportive environment Confidence Authority to lead
Several factors affect the delivery of PBS and one of which is having staff who are accountable and ready to make a difference. A concerted effort re PBS is welcomed. This gives nurses the status that they deserve for their relationship with service users and others. There is appreciation and recognition that nurses and others need to work as a team in PBS delivery, and that no one discipline can achieve this on their own. The idea of reflective practice and the use of a reflective journal/diary that would help nurses to improve PBS practice. A clear and systematic approach was lacking in the delivery of PBS as staff were not working together but in silos. PBS is not the issue as it is recognised as a useful framework, the issue is more about human factors such as a lack of communication between staff.	Change Collaboration Working in silos Improving patient care Teamworking Consistency
RMN 9 is of the view that clinical psychologists have the preparation, education and have done the research on PBS to be PBS practice leaders. A lack of empowerment and confidence from some nurses has contributed towards clinical psychologists taking a leading position in the field of PBS. Psychologists are familiar with PBS and therefore comfortable with the intervention compared to nurses.	Highly regarded Knowledgeable Weakness /gaps Who knows more? Seen as experts Barriers

PBS framework and its principles have been successfully used in other areas of need. There is clear understanding of how PBS can influence care in general and, while doing so, have due consideration for patients' safety. Patients have a right to be given all the support and care that they need including during the pandemic lockdown and restrictions on the wards. PBS could have served some benefit to the patients. The nurse wants to practice an intervention confident in the knowledge underpinning it. Nurses remain aware of the importance of evidence base practice in understanding behaviours Like a reward chart, a traffic light system may find a place within PBS, but that would give the impression that PBS is a behaviour modification strategy rather than a framework that helps understand patients' needs and improves quality of life. There is an understanding that the principle aim of PBS is all about respecting the human rights of the individuals, albeit those whose behaviours are challenging.	Safety is a primary aim Duty of care Paternalistic at times Respect and dignity Understanding behaviour Human rights
To achieve a structured and multi-agency approach to PBS, there is a real need for leadership and commitment from experienced individuals. It is crucial that service users take the centre stage in PBS as doing so may initiate the whole concept of consumer leadership in care. Nurses are tasked to ensure there is an MDT approach to PBS practice. This could be because of nurses' ability to ensure patients form part of the decision-making process. Nurses need recognition and appreciation from others of what they can contribute regarding PBS.	Practice leaders Co-production Consumer leads Recognition Leadership MDT approach
It is accepted that PBS is mainly about the ethical use of interventions to help patients with complex needs without using restrictive interventions as a first resort. PBS is effective when it is delivered in its simplest form without sophistication. A clear and simple PBS plan needs to contain the relevant information that will help the patient and the many stakeholders supporting the patient. It can prevent escalation of certain behaviours. There is optimism that PBS could be useful in community services, despite on-going discourse on the need for staff to know more about the model. Nurses are still asking questions about PBS that remain unanswered in a clear and concise way. The unknown can be anxiety provoking for many nurses.	Supportive intervention Ethically sound Needing clarity Help reduce behaviours of concern Multi-component Reduces challenging behaviour Appraisal of a new construct

Table 5: Development of emergent themes.

5.2.3 Clustering of emergent themes under one sub-theme for RMN 9

Table 6 (below) shows relevant emergent themes that were grouped together to form sub-themes.

Sub-themes	Emergent themes
Confidence	Awareness/ Pre-reg/Attitude/Professional identity/Relationship Ability to ask for training The need to be empowered Comfortable within a system Supportive environment
Authority to lead	Capacity/ Capability/ Professional identify
Teamworking	Quality of care/Visible leadership/Staffing/Collaboration/Co-production/ Common goal Change Collaboration Working in silos Improving patient care
Consistency	Evidence based/Maldistribution of nurses
Seen as experts	Psychological model/Leaders/Education Nurses passive Highly regarded Knowledgeable Weakness/gaps Who know more?
Barriers	Supremacy/Hierarchy/Patient engagement
Understanding behaviour	Expertise/Education/Function Safety is a primary aim Duty of care Paternalistic at times Respect and dignity
Human rights	Ethics Compassion Dignity Respect/Relationship Safeguard/Quality of life
Leadership	Opportunities/Role model/Practice leaders Practice leaders Co-production Consumer leads Recognition
MDT approach	Rapport/Professional socialisation/consistency
Multi-component	Various elements A number of strategies Other interventions

	A package Blurred process Supportive intervention Ethically sound Needing clarity Help reduce behaviours of concern
Reduces challenging behaviour	Support Quality of life
Appraisal of a new construct	Awareness/Something new to us/Starting to understand Embedding

Table 6: Clustering of themes.

5.2.4 Development of themes

The process, as shown above, was repeated for each transcript. Table 7 (below) illustrates how the different themes were developed, and here I have taken a selection of examples illustrating how the first constructs were interpreted (to achieve the second construct) and how these interpretations became the sub-themes and main themes. The additional notes that I took during the interview were brief but useful during interpretation of the interviews.

First construct	Second construct (interpretation notes)	Sub-themes	Themes
'I think it's the way things are structured. If you empowered people and said 'we need you to take a lead on this', then this empowerment helps nurses to bring about the confidence. There are also the MDT effects; nurses do not want to cross the boundaries. It is not a case that you do not know what to do, it is more about leaving it to the one who is supposed to be doing it.' (RNLD 6)	PBS awareness does not have to be sophisticated or achieved through a complex teaching process. A working knowledge can be the start of developing a leadership position in PBS. A nurse, as any professional, needs education, awareness, and the opportunity to be empowered. Respectful of boundaries and hierarchy, nurses often leave PBS to others, especially if they feel lacking in competence or skills. A lack of education or training may make nurses feel they require validation from others.	Authority to lead	Training
'There's also the idea of mentoring and supervision whereby junior nurses could be supervised using PBS in practice.' (RMN 9)	Nurses can contribute towards PBS implementation and they identify equal access to structured training as essential. First-hand information and knowledge from a reliable source that depicts PBS as a practical framework is much welcomed. It is not enough to just satisfy curiosity about what PBS is. Nurses need more knowledge so their practice is informed. PBS training opportunities can potentially help nurses in a MDT context where everybody shares knowledge and competence equally. A supportive process or system can be helpful in coaching or mentoring those in need towards their professional/personal development in PBS.	Confidence	Training
'When it comes to team discussions, not everyone in the team necessarily agrees and comes to the same agreement on PBS. It's about following what is in the plan, each and every staff doing the same thing.' (RMN 1)	It is more acceptable that disagreements are heard by a team and, when a decision is made, PBS plans are accepted, and service users supported in its implementation compared to when these disagreements are not considered at all.	Teamworking	Resources

'In summary, the PBS plan is written in a way that it can be picked up by anybody in the care of the service user and follow it up.' (RNLD 7)	The formulation of the PBS plan is essential to ensure continuity of care and, most importantly, that service users can relate to it. The nurse accepts that a succinct and explicit plan helps facilitate a consistent approach to PBS care delivery.	Consistency	Resources
'The people who create the PBS plan do not necessarily know more than what nurses do.' (RNLD 10)	The creation of a PBS plan should not be a one-person task. Nurses are skilled at establishing good rapport with service users so their input should not be disregarded.	Barriers	Psychology-led practice
'Psychologists and occupational therapists are the main people taking a lead in PBS, but nurses are very much engaged in the process – in ensuring PBS is being delivered.'(RMN 2)	A coalition between disciplines that disregards nurses' competence and knowledge of patients' needs regarding PBS is a serious issue.	Seen as experts	Psychology-led practice
'I think with PBS it's about looking at the bigger picture and see how we can, as nurses, as support workers get to understand the client and see how our actions, how the environment, interacts with that client.' (RNLD 5)	A learning disability nurse describes PBS as a tool that could assist staff understand service users' presentation in relation to their environment and their relationship with staff.	Understanding behaviour	Restrictive interventions
'PBS is different from other interventions as it is a dignified approach to challenging behaviour. It helps maintain respect for the individual and takes us away from inappropriate and degrading treatment that service users have endured in the past.' (RMN 2)	Valuing the person is the ultimate essence of PBS, which means caring for someone without compromising on the fundamental of patients' rights.	Human rights	Restrictive interventions
'Not to minimise the significance of working within a team where staff support each other, and also having someone senior to ensure the team is unified.' (RMN 3)	Nurses place considerable importance on support systems within teams and the formation of a stable and supportive team ethos. A team that worked well together requires proper management and clear leadership.	Leadership	Communication
'Quite useful to hear from different disciplines and expertise that people were using PBS in many different ways with their clients, so that was quite good.' (RNLD 11)	There are areas where the MDT and other stakeholders have been actively involved in the implementation of PBS.	MDT approach	Communication

'I do not think PBS on its own is enough to achieve objectives. There is always need to have person-centred approach to care and PBS provides that.' (RNLD 7)	There is recognition that PBS cannot and should not be considered as the answer to all issues in mental health/learning disability services. PBS can form part of other interventions. An individualised approach is much needed.	Multi-component	Effectiveness
'This is new to many of us. We are still learning a lot about it and I think there should be continuing support in this journey.' (RNLD 12)	As a new construct for many nurses, the full impact of PBS is still being evaluated in practice.	Appraising a new construct	Effectiveness
'*There are examples of violence, aggression and other restrictive interventions that can be avoided with the effective use of PBS.'* (RMN 14)	PBS has shown that some of the practices could have been avoided and are deemed unnecessary if evidence-based practices are used.	Reduces behaviours that challenge	Effectiveness

Table 7: Development of themes.

5.2.5 Each transcript, with recurring sub-themes across the participants and main themes (See Appendix 14)

The process that I embarked on, as shown in Table 6 and 7, was repeated for each transcript, the texts of which are attached in Appendix 14. The interview quotes in Appendix 14 were chosen to depict the participants' positions, characters, values, and beliefs in relation to the theme being presented. By proceeding in this manner, I offer an understanding of how the participants' accounts and experiences have constructed a rich description of the phenomenon being investigated. The inclusion of specific and most relevant quotes was to compile an account of how the participants' experiences illuminate the phenomenon of PBS.

Quoted extracts from the interview serve to show points that are relevant and, moreover, significant. The choice of extracts and participants in this section was based on the articulation of their depth of experience of PBS in relation to the various points they wanted to make. All participants were represented in this chapter. Quotes were selected that encapsulate a rich understanding of PBS. My aim in selecting them, was to somehow portray the experience of both mental health and learning disability nurses as they occupy different sections on the NMC register, hence their training and scope of practice would differ to a certain extent; taking that into consideration, their differing experiences and perceptions of PBS may prove of interest.

5.2.6 The themes and sub-themes

Themes	**Sub-themes**
Training	(i) Confidence (ii) Authority to lead
Resources	(i) Teamworking (ii) Consistency
Psychology-led Practice	(i) Seen as experts (ii) Barriers
Restrictive Interventions	(i) Understanding behaviour (ii) Human rights
Communication	(i) Leadership (ii) MDT approach
Effectiveness	(i) Multi-component (ii) Reduces behaviours that challenging (iii) Appraising a new construct

Table 8: Illustration of themes and sub-themes.

5.3 Findings

Overview of the themes

The section above has described the process undertaken during my interpretation work. Six themes emerged from this process as shown in Table 8 (above)

In this section I will examine each theme, alongside the first construct that described the participants' experience of PBS and use transcripts to showcase my findings.

5.3.1 Theme 1: Training

Participant RNLD 10 said:

'In-house ongoing session and away days would not make a person an expert in PBS. However, what it does is, it creates a level of awareness that you could safely use the model with patient.' (RNLD 10).

Both RMN 1 and RNLD 6 feel that some form of structured training would benefit nurses and other colleagues in applying PBS effectively.

'It is the lack of training, because people are not well trained, this is how we implement the framework, this is how we should follow this to support particular clients' (RMN 1)

'It would not really matter whether the training is in-house or external as long as it is extensive and practical. A training that is enough to empower nurses to not only understand the process of PBS but also to be able to lead a team to deliver it.' (RNLD 6)

RMN 9 thinks PBS training would allow nurses to bring a higher level of contribution if they had high level training:

'Nurses were quite involved in bringing ideas together, but it would have been much better if all of us had some formal training on PBS.' (RMN 9)

The need for on-going PBS training was referred to as essential for the maintenance of proficiency in PBS as described by RNLD 12:

'Because, as you know, repetition is important for staff to remember – it also helps to remove some of the bad practice, mistakes, but more importantly people wouldn't forget about it.' (RNLD 12)

Participants observed that for the PBS framework to be consistently applied, and to achieve the desired outcomes, the practice depended on staff awareness, but also on their experience and quality of exposure. One nurse said:

'It was in my second year while at university as a student nurse. We attend this conference every year where there is somebody who talks about PBS for everybody to be aware of how it [PBS] can be used to support clients more effectively. So that is when I heard about it and then, after that, I never heard of PBS – even during my placements.' (RNLD 5)

The idea of knowing what PBS is, and why it is used, is strongly resonated by RMN 9 and RNLD 11 who explained:

'I think it was going by what has been said rather than we doing this, because of, like, giving us more in-depth knowledge in the sense of why and what PBS is.' (RMN 9)

'The more you train staff the more up-to-date they are with the model and they can relate with the practical aspect of it. You can never have enough training because there are always changes.' (RNLD 11)

'Why we are doing it and what is the difference…' (RMN 9)

Another nurse explained how her exposure to a ward where PBS was being used had helped her understanding:

'On the LD ward where I was moved to, PBS was one of the main interventions. There was a lot of engagement with PBS and professionals were very motivated, and I became more aware of the practice and its features.' (RMN 2)

And it was in clinical practice where one nurse first became aware of PBS following a brief talk by an external training agency. He said:

> *'I worked on a learning disabilities ward and I can remember – I think it was three or four years ago – we had someone who came from external, a speaker who came to talk to us about PBS; she told us about PBS, what the intervention was about.*' (RMN 1)

From another angle, a nurse with a psychology background found her previous studies useful because she understood the purpose of PBS. The nurse said:

> *'Having worked on X ward for a number of years, and also having a psychology background, has helped me understand PBS concept and how effective it is.'* (RMN 2)

Nurses RMN 3 and RNLD 10 said this:

> *'During my university training I became aware of PBS. We were given a hand-out and then we went through the slides for half an hour/45 minutes. Then when I started working as a nurse I came across PBS again. However, there was nobody, as such, to give us a lecture. Eventually psychologists were delivering brief basic sessions on PBS. Psychologists were the one who were more involved with PBS.'* (RMN 3)

> *'My training as a learning disability nurse give me the skill to understand behaviour and where the patient is coming from by displaying a particular behaviour; and also, what evidence-based practice that would be most appropriate in a given situation.'* (RNLD 10)

RMN 9 accepts that PBS training helps put staff at the same level of understanding.

> *'This situation would put nurses at the level where there would be no argument because everybody would be at the same level with regard to knowledge, competence and skills.'* (RMN 9)

This levelling up in confidence emerges strongly in the sub-theme below.

5.3.1.1 Sub-theme: Confidence

During interviews the participants expressed a lack of confidence. RMN 2 and RMN 8 stated:

> *'PBS as an intervention requires some sort of awareness, and nurses perhaps did not have it. Or they do not get it. This is why nurses were limited to only ensuring the intervention was offered to service users.'* (RMN 2)

> *'This ensured that staff had awareness of the model and that PBS was being used in an informed way.'* (RMN 8)

RNLD 6 talked about their professional and personal development to enhance confidence:

> *'I think it's the way things are structured. If you empowered people and said, 'we need you to take a lead on this' then this empowerment helps nurses to bring about the confidence. There are also the MDT effects; nurses do not want to cross the boundaries. It is not a case that you do not know what to do; it is more about leaving it to the one who is supposed to be doing it.'* (RNLD 6)

One nurse mentioned a lack of opportunities in the field of PBS, which impact negatively on confidence:

> *'I think it is part of their [clinical psychologists'] training… education. I think they have more knowledge on this than nurses. If we could also train nurses, then that would be useful. Psychologists are also very willing to learn and develop strategies. Nurses are somewhat reluctant to do so. This could be because of lack of opportunities, lack of confidence, or just a lack of interest.'* (RNLD 5)

RMN 3, with 3 years' post-registration clinical experience, was of the view that nurses were often too comfortable in their clinical roles:

> *'There is a lack of interest; a lack of confidence and training. Nurses are too comfortable in their roles. It goes back to how nurses are trained in the first place.*

How different our training is to that of psychologists and OTs. We need to review our formation to start with. Not all psychologists are experts in PBS, but they seem to have developed an interest in the framework.' (RMN 3)

Another form of support during PBS implementation was identified as supervision and mentoring:

'There's also the idea of mentoring and supervision whereby junior nurses could be supervised using PBS in practice.' (RMN 9)

RMN 9 raised the issue of collegial support in the implementation of PBS. RMN 14 refers to a concern that PBS can be reduced to a simple tokenistic exercise without the necessary awareness and feels that knowledge is linked with confidence. It is also claimed that some staff did had no understanding of PBS:

'Staff may see PBS plan as a piece of useless paper, only because they are not aware of the scientific evidence underpinning it.' (RMN 14)

'I think knowledge brings the confidence – and we need both.' (RMN 14)

'I suppose I was one of those people that were saying 'yeah, yeah, yeah'. When in fact I had no clue.' (RMN 16)

Participants spoke about the development of PBS plan through a form of mandatory PBS training to build capacity and a skilled workforce:

'It is useful to try and see how a PBS plan can be developed and how you can support a person who has complex needs and challenges.' (RMN 16)

'PBS training mandatory, but having a yearly update at least, would help staff and patients.' (RMN 17)

'…but having that course to do, I think just helps you feel as if, like, you know what you are doing.' (RNLD 18)

5.3.1.2 Sub-theme: Authority to Lead

One nurse (RMN 4) said she needed confidence before feeling qualified to lead:

> *'It would be good to have the confidence, I should say, to be able to implement PBS. It is not about the psychologist to come and tell us about PBS.'* (RMN 4)

Participants described certain perceptions about nurses being 'doers' and not leaders. They claimed:

> *'Nurses perhaps were not asked to lead; but it is also about how much nurses know about PBS. Nurses are often seen as the ones to put in action any intervention or care plans rather than facilitating.'* (RMN 2)

> *'We definitely need to make nurses become more competent with more training. And also, to be able to trust in their abilities and their knowledge.'* (RNLD 12)

Another nurse (RNLD 6), with approximately 10 years' experience as an LD nurse, observed that nurses needed support, to be enthused and inspired to take on a role outside their comfort zone. RNLD 6 also believed encouragement and empowerment could raise nurses' confidence of PBS. She claimed nurses were wary to venture into unknown terrains that seem meant for someone else to occupy:

> *'I think it is the way things are structured. If you empower people and say we need you to take a lead on… then this empowerment will help nurses to bring about the confidence. There is also the MDT effect; nurses do not want to cross boundaries. It is not a case that you do not know what to do; it is more about leaving it to the ones who are supposed to be doing it.*' (RNLD 6)

Participants distinguish between a learning disability ward and a mental health ward where PBS is applied differently, and talked about pre-registration nurse training:

> *'This was a learning disability ward, and I think they were very much advanced in PBS compared to my ward. The nurses have had exposure and preparation to use the framework'* (RMN 8)

'...because in our nurse training I didn't have anything that was based around PBS and there were limitations around this.' (RMN 16)

In summary, nurses' experience of PBS informed them that training was essential for the framework to work effectively. This indicated that PBS training could have increased their confidence, which could consequently improve their ability to lead the practice within an MDT context.

5.3.2 Theme 2: Resources

One participant summarised the effects of resources on the care delivery in mental health services:

'So, I am not giving excuses but these are the reality of the current situation and, to be honest, even without the Covid-19 pandemic we already had issues around resources, specially registered nurses. And this wasn't only a local issue but a nationwide problem.' (RMN 9)

5.3.2.1 Sub-theme: Teamworking

Many participants referred to teamworking as imperative for the good of PBS and for the benefit of service users. Nurse RMN 4 stated:

'We need more than just a good PBS plan; we need staff to believe in the framework. We want attitudes to change so that PBS can be fully implemented. What we also need is everybody working together with the service users and not just a couple of individuals coming up with a plan without wider consultation.' (RMN 4)

Another participant claimed:

'The MDT agrees to a plan of how we support service users with challenging behaviours, so then PBS works well.'

'When it comes to team discussions, not everyone in the team necessarily agrees and comes to the same agreement on PBS. It's about following what is in the plan, each and every staff doing the same thing.'

'The other thing is a lack of staffing that compromises the delivery of PBS.' (RMN 1)

RNLD 7 expressed that clinical psychologists have developed rapport with nurses so there is a reinforced teamworking atmosphere is some clinical areas:

'The psychologist has developed good rapport with the team, so most colleagues would go to them for advice regarding PBS.'

Participants referred to how clinical psychologists work in some areas where the development of a PBS plan is carried out by one discipline:

'The way it worked was that the clinical psychologist would get feedback from MDT and would go away to develop a PBS plan.' (RMN 8)

'There was an element of trust in that kind of approach, but there's also the issue of working together in collaboration and not an attitude of me knowing more than you kind of thing.' (RNLD 11)

When asked how she would improve teamworking, RNLD 5 said:

'So what I would do is make sure the team is communicating well, delegate properly, that is support workers, key workers, monthly meetings, fortnightly meetings, to then discuss how is it working, what do we need to do… delegating to other staff and engage in team effort.'

Participants argue for better collaboration between all colleagues including healthcare assistants:

'And I would want to see everybody contributing to the model rather than having one discipline leading its implementation.' (RMN 9)

'Qualified nurses were, but the other healthcare assistants were not necessarily aware of PBS.' (RNLD 12)

Reference is made to a collaborative approach at service level in the delivery of PBS, where each member and discipline works together with nurses:

'Also making sure that nurses are working in collaboration with everybody else including psychologists and medical doctors so that there is a full MDT approach to the implementation of the framework.' (RMN 9)

Teamworking in relation to PBS was a way of learning from each other, irrespective of status:

'Sometimes you may have the qualification, but you can always forget, and you also learn from everybody within the team.' (RNLD 12).

Nurse RMN 1, with almost 12 years post-registration experience in MH and LD services said:

'This was agreed by the MDT, but I was not part of the decision-making. Nurses' role regarding PBS was to feedback to the team on the presentation of the service user following PBS. The feedback goes to the psychologist during ward rounds.' (RMN 1)

Participants referred to teamworking as primarily about working together to achieve common purposes, but it was also about staff connecting with each other. It was described as fundamental to the success of PBS:

'Working with the same set of objectives is quite important for PBS to be successful. Everybody should be liaising with each other and be united.' (RMN 2)

'We had a supportive team, so we have been able to come together with PBS and make it work.' (RMN 15)

'Maybe we could not have got this done without the help of the OT.' (RMN 15)

'...but to get different disciplines to work together as well, so that the approach is not disjointed.' (RMN 16)

5.3.2.2 Sub-theme: Consistency

Consistency appeared as a constant sub-theme during data interpretation. Nurses mentioned it as follows:

'We need consistency, continuity and effort from each and everybody within a team for the intervention (PBS) to work.' (RNLD 6)

'It could also consist of a mini-diary that reflects what needs to be done… the type of thing that people would want to do.' (RMN 9)

As mentioned above, a lack of consistency was also put down to an absence of substantive staff:

'Inconsistency comes due to a lack of training; because people are not well trained, not been told how to implement the framework; not shown how to follow PBS plans with particular clients. The other thing I can say is there is a shortage of nursing staff.' (RMN 1)

An LD nurse with two years post-registration experience talked about how PBS could be negatively influenced by lack of unity within a team:

'Not everyone in a team comes to the same agreement on the issue of PBS. It is about following what is in a PBS plan; every staff doing the same thing. When a team is split in the way they see PBS, there is inconsistency. This is also because of a lack of training and awareness. Staff employs PBS the way they feel like it.' (RNLD 5)

RNLD 11 valued the role of the clinical psychologists in relation to PBS:

'I think we have been quite lucky in the sense of the psychologist understood that nurses were the one who have a better rapport with the service users… and that nurses would be the one who would ensure the implementation of this model.'

RNLD 5 and RMN 9 alluded to challenges that staff faced in relation to PBS:

'My colleague who devised PBS plans said staff do not follow the plan. Day staff doing one thing, night staff doing something different. There is a lack of consistency. They forget about PBS; it is in a folder on a shelf, nobody is referring to it, nobody is using it.' (RNLD 5)

'So, to a certain degree it worked, but the difficulty that we had was consistency or a lot of consistency because staff were not following the plan.' (RMN 9)

However, RNLD 7 accepts that a succinct and explicit plan does facilitate a consistent approach to PBS care delivery:

'In summary, the PBS plan is written in a way that it can be picked up by anybody in the care of the service user and follow it up.' (RNLD 7)

Participants described the importance of resources from various perspectives:

'…remind staff that once they are on shift, they know what works for which patient and that things need to be done.' (RMN 14)

*'I think having permanent staff working with our patients is also important and not relying on agency staff.' (*RMN 14)

'…because we actually have all of our patients on a PBS plan, so we have regular monthly PBS discussion.' (RMN 17)

In summary, nurses have reported teamworking and consistency as two essential requirements for PBS to deliver its objectives successfully.

5.3.3 Theme 3: Psychology-led Practice

Participants described PBS as a psychology-dominated intervention. Nurses perceived clinical psychologists as PBS experts. However, they remained sceptical as such a situation could be a barrier to PBS's success, despite clinical psychologists being essential to the delivery of in-house PBS support and training:

> *'…but on the ward where I am at the moment there is ongoing training provided by clinical psychologist.'* (RNLD 10)

5.3.3.1 Sub-theme: Seen as Experts

Clinical psychologists were the experts and leading figures in PBS. RMN 4 saw clinical psychologists as PBS leaders due to their authority in developing PBS plans for patients. Similarly, RMN 9 considered clinical psychologists to have the preparation, PBS education and research awareness for them to be valid PBS practice leaders:

> *'Psychologists are the leads; they develop the plans and they pass them on to the team. They are the ones who decide what to include in PBS plans.'* (RMN 4)

> *'I think credit to them [clinical psychologists]. They have done some research around it and they know a lot more about the model, so they know why they are doing what they are doing – and we don't.'* (RMN 9)

> *'I also feel conversations with expert colleagues, and working closely with colleagues who are skilled, competent and knowledgeable, is as important as formal training.'* (RNLD 7)

PBS was well received by a group of highly committed nurses at RMN 2's clinical practice. However, again, nurses were facilitators and not leaders:

> *'Psychologists and occupational therapists are the main people taking a lead in PBS, but nurses are very much engaged in the process, in ensuring PBS is being delivered.'* (RMN 2)

'So, technically, the psychologists who are designing the plans rely heavily on the feedback and the narratives from the nurses.' (RNLD 12)

Similarly, RNLD 5 felt nurses could lead and deliver PBS, provided they received adequate training:

'We don't have to rely just on psychologists; nurses can do this. I could go out and help put a PBS plan [in place] and, in actual fact, probably we are more suitable to deliver PBS; but we need to have the education.' (RNLD 5)

A few participants found a rationale for clinical psychologists to take a leading role in PBS:

'PBS being a behavioural approach does put psychologists in the right position to lead PBS, as they understand behaviour better.' (RMN 8)

'I just assume that they have more knowledge than anybody else on the subject… and that they have the training to make them competent.' (RNLD 11)

Conversely, a few participants suggested that psychologists were not necessarily the most appropriate colleagues to lead PBS:

'Of course clinical psychologists do a good job, but they come to the ward once a week, or twice a week, and see the patients for half an hour or forty-five minutes and they just go off; and they go and write a PBS plan.' (RMN 3)

'To be honest they say conflict sometime… because the person who is twenty-four hours with someone… and then you coming two days in a week.' (RNLD 12)

When probed about their views as to why clinical psychologists were often the leading figures in PBS, one nurse said:

'I think purely [from my perspective] it is the training that psychologists have had. Their education helps them better understand interventions like PBS. Nurses are doers; they will get on with it by helping with the implementation of PBS. In terms of taking a lead in doing behavioural plans it's always the psychologist.' (RMN 1)

It is supposed that, when it comes to behavioural approaches, it has always been psychologists' areas of expertise, and this was why PBS has remained the psychologists' domain:

'If you look at the current environment, [clinical] psychologists are the ones who lead on matters involving behaviours [of concern]. Psychiatrists deal with mental health issues and us nurses; we are the one who follow the instructions, which is unfortunate.' (RNLD 6)

RMN 4 said:

'Psychologists are very willing to learn and develop strategies. Nurses are somewhat reluctant to do so. This could be because of lack of opportunities, lack of confidence or just a lack of interest.' (RMN 4)

Participants spoke about the important role of clinical psychologists in supporting PBS in practice:

'The assumption is that psychologists have the knowledge, skills and competence to manage PBS.' (RMN 14)

'I know clinical psychologist was involved in the in-house training, so I found it very useful.' (RMN 15)

'…but I would assume that maybe they have some type of training that relates to the implementation of PBS.' (RMN 16)

'…this was delivered by the psychologists on the ward, and they have taken a lead on the implementation of PBS.' (RMN 17)

'We did the PBS training and… because the psychologist had done the course, so they were, like, already aware of behaviour and behavioural approach.' (RNLD 18)

5.3.3.2 Sub-theme: Barriers

Many nurses reported the barriers and challenges at play when using PBS:

'Patients were not fully involved in the PBS programme. By me saying this, I mean patients may have a meeting with the psychologist without the involvement of a nurse. He [the clinical psychologist] may not know what was discussed at handover. But I think it is essential to engage nurses in the process. An absence of nurses may mean a lack of leadership from them.' (RMN 1)

PBS was described as not working due to lack of training, which was seen as a barrier to apply evidence-based practice:

'From my experience in some situations, PBS did not work not because it was a bad plan – it was mainly because many staff did not know what PBS was.' (RMN 8)

RNLD 6 believed that senior MDT members, such as psychiatrists, play an important role in deciding who should lead PBS. She said:

'If we have a situation whereby the psychiatrist suggests nurses should take a lead, then nurses will be more engaged with this. You will find people who would want to be involved. There are a few nurses who are very good at PBS but never had the chance to be involved at that level.' (RNLD 6)

Participants also exposed other challenges:

'What are you doing to challenge if you do not know how it works and you do not have the knowledge behind you?' (RMN 9)

'You can train someone – I'll provide everything to empower nurses – but there is always the personal willingness and commitment that is quite important.' (RNLD 12)

'I think it would be harder to implement PBS in the community because it may become quite difficult to track progress; and what you wouldn't want to happen is PBS to become just a piece of paper for the sake of it rather than being a live document as it is on the ward.' (RNLD 11)

Comments were made on psychologists' positions within the MDT, the role of psychiatrists, and nurses' attitude and engagement in PBS. RMN 2 explained:

'Once psychologists have positioned themselves as leaders, and this being acknowledged by senior members of the MDT [psychiatrists], then nurses find it difficult to become interested in or even taking the role of leader. There is a degree of unwillingness to engage. This is not necessarily being unprofessional but there is a lack of cohesion.' (RMN 2)

Participants talked about their knowledge of patients not being used effectively and described the need to work in a co-productive manner:

'The people who create the PBS plan do not necessarily know more than what nurses do.' (RNLD 10)

'Nurses and other disciplines seem not be part of the process, and most of the time not being aware of what is happening.' (RMN 14)

'Psychologists don't spend as much time with these patients as we [nurses] do, and I think as a nurse.' (RMN 16)

'We have the service users and talking to the family and getting everybody on board rather than just being a psychology mainly led…' (RMN 17)

In summary, nurses in this study considered clinical psychologists to be PBS leaders, although some expressed that this should not necessarily be the case. Nurses explained the barriers and challenges that arise due to clinical psychologists taking the principal role in PBS. During data analysis it was found that, although many nurses wished to gain confidence

in leading PBS, they welcomed more opportunities for nurses to lead the practice in an MDT context.

5.3.4 Theme 4: Restrictive Interventions

The use of restrictive interventions and a reward system linked to the use of PBS became evident:

> *'Let's say service users are not behaving well, then they know they are not getting that reward… that is what I have noticed; and they feel a bit like they have let themselves down. They have to start again to earn that reward.'* (RMN 3)

> *'…ward there was a lot of issues and tension around drugs use so staff would often end up involved in physical restraint seclusion and other restrictive intervention.'* (RMN 9)

> *'In some cases, PBS has helped service users going back in in-patient's services where seclusion and restraint could have been the outcomes in some extreme cases.'* (RNLD 7)

> *'Currently, Covid-19 has changed the ward environment so patients are facing a lot more restrictive intervention. Therefore, PBS could have been used to support these service users.'* (RMN 9)

5.3.4.1 Sub-theme: Understanding Behaviour

The nurses commented that a good understanding of challenging behaviour could change practice and certainly help reduce restrictive interventions and improve quality of life:

> *'So, PBS focusses on least restrictive practices as our feeling is that if someone presents as challenging then they are so for a reason. So, it's not about being punitive or taking away any privileges. It is more about working with that person to look at other ways to ask for things or deal with situations.'* (RNLD 6)

> *'We try to make plans within ourselves in terms of how we come to help the quality of life of patients, such as reducing the number of behaviours of concern.'* (RNLD 11)

Education on challenging behaviour could help clinicians and other stakeholders to adopt appropriate strategies in supporting individuals who exhibit difficult behaviours. This awareness could contribute towards reducing the administration of medications to deal with challenging behaviour:

> *'Different teams under the same ward can work differently. Some share the views that medications work better than PBS with regard to addressing challenging behaviour.'* (RMN 4)

> *'But you just lose interest while you don't know the essence of why you're doing what you're doing.'* (RMN 9)

> *'…concerned us, but we have to take into consideration what has happened and how do we prevent that from happening. Like, do you know any signs of relapse and how do you feel like if it's going to come up again.'* (RNLD 11)

An LD nurse describes PBS as a tool that could aid staff understanding of service users' presentation in relation to their environment and their relationship with staff. They observed:

> *'I think, with PBS, it's about looking at the bigger picture and see how we can, as nurses, as support workers, get to understand the client and see how our actions, how the environment, interacts with that client.'* (RNLD 5)

Other interventions were found useful in delivering a PBS approach:

> *'Traffic light system may not be tackling the problem. Instead it could be a system whereby certain behaviours are deemed acceptable and others are not.'* (RMN 9)

There were accounts of PBS's attributes:

> *'PBS has done a lot of good in the field of challenging behaviour. Staff, by using PBS, need to work with service users and other stakeholders to fully appreciate service users' demeanour and explore what will help towards addressing them.'* (RMN 2)

'When you are doing a PBS plan you tend to accommodate what would change the behaviour of the patients, and we are looking at what to accommodate to adapt for him or her… how we can improve.' (RNLD 12)

Participants shared their experience of the PBS framework to understand behaviour through a holistic approach:

'…think that it's important that we have a good therapeutic relationship with our patients.' (RMN 14)

*'Knowing the past trauma of an individual helps understand the care that the person requires and what re-traumatise the person.' (*RMN 14)

'And I think also it ties in with the trauma-informed approach to care that people didn't understand.' (RMN 15)

'We have to look at things like the history, the physical health, emotional needs of this person.' (RMN 16)

5.3.4.2 Sub-Theme: Human Rights

Most nurses interviewed for this study placed huge significance on human rights' aspects as they apply to service users. RMN 1 and RMN 2 stated:

'I mean, supporting service users in areas that are positive for them to have a meaningful day, because after all it is a day to day thing… where the person may slip out a bit of the goal. Instead of talking more about the positives, we revert back to use punitive and restrictive measures.' (RMN 1)

'PBS is different from other interventions as it is a dignified approach to challenging behaviour. It helps maintain respect for the individual and takes us away from inappropriate and degrading treatment that service users have endured in the past.' (RMN 2)

Participants talked about patients' rights to be given high quality care by making the necessary adjustments and considerations:

> *'We have to make necessary adjustments such as pictorial, easy-read formats of PBS, including plans written in first person in a co-productive way.'* (RNLD 7)

> *'And it is supposed to be supporting the individual rather than being punitive or infringing on people's human rights.'* (RMN 9)

> *'I think sometimes… not necessarily all the time… understanding could be a barrier. But I can't think of any other barriers as long as we empower patients to take control of their care and we provide a platform and opportunities for them to be able to do that, then there shouldn't be major issues.'* (RNLD 11)

Another participant explored practices during which service users were placed in seclusion or long-term segregation following incidents. However, in some areas, the treatment that service users received was greatly improved and was different from past practices, especially with the advent of PBS:

> *'In similar situations in the past, the person would be taken to seclusion or have their leave suspended, or something of that kind. We decided we would not go down that road.'* (RNLD 6)

> *'It helps situations not reaching escalation point and it reduces the need to use PRN medications.'* (RNLD 7)

> *'A robust risk assessment is needed to make sure that when a patient is admitted on a particular ward that the ward is where this person should be.'* (RNLD 10)

The human value aspect of individuals receiving treatment is of prime importance. The nurses in this study appeared cognisant of past incidents of abuse and they understood the difference that PBS made:

'PBS is a model that is different in the sense that it takes into consideration the human value of individuals. We know in the past service users have been ill-treated and there has been abuse and violation of basic human values.' (RMN 3)

'It's extremely important to involve the service users in the planning and to get their views about anything and everything.' (RNLD 12)

'…that if we do things appropriately, and as and when necessary, we will avoid the person getting to a stage where there is violence.' (RMN 14)

'We also link it back to, like, quality of life and, like, ensuring like participation in activities.' (RNLD 18)

'We worked very long in the positive behavior support model to keep him at home.' (RNLD 19)

In summary, participants acknowledged an excessive use of restrictive interventions in the absence of PBS. Restrictive interventions were linked to poor understanding of challenging behaviours and the human rights of individuals. The nurses claimed it was pivotal for them to understand behaviour, and this awareness was relevant when using PBS.

5.3.5 Theme 5: Communication

The fifth theme that emerged from the data was 'communication'; its sub-themes being 'leadership' and 'MDT approach'. The participants emphasised teamworking as an important feature to bring about consistent and effective collaborative work:

'I think PBS works. It has worked, but yet, I think it was not communicated well to the staff.' (RMN 3)

'I think it's all good to plan, and that's it… and leave the plan up in the air really, but I think it's an on-going assessment and on-going communication with the patients, it has to be.' (RMN 3)

'In my services there is a shared drive that everybody will have access while conforming to the GDPR regulations.' (RNLD 5)

The data highlighted how many of the participants strongly valued a consistent approach and clear communication among staff and service users. Nurses explained:

'So, what I would do is make sure the team is communicating well, delegate properly, i.e. support workers, key workers; monthly meetings, fortnightly meetings, to then discuss how is it working, what do we need to do; delegating to other staff and engage in team effort.'(RMN 3)

'There will always be an issue, specially in a learning disability sector. However you can overcome that problem somehow by being available, and making all of the reasonable adjustment with the patients so that communication does not become a barrier.' (RNLD 11)

'We explained the whole approach to the patient and staff so that we were consistent and clear about what we wanted to achieve.' (RMN 15)

5.3.5.1 Sub-Theme: Leadership

Nurses RNLD 6, RMN 3 and RMN 2 indicated that leadership was pivotal to developing and facilitating PBS in their clinical practice:

'We need consistency, continuity and effort from each and every body within a team for the intervention to work. This is what we are looking to achieve as at times we have people who will do something for a month and, then, if they do not see any changes within a short period of time, they go back to what it used to be.' (RNLD 6)

'...more about a team approach – and I would want to see everybody contributing to the model rather than having one discipline leading its implementation.' (RMN 9)

RMN 3 and RMN 9 placed considerable importance on a support system within teams and forming a stable and supportive team ethos:

'…not to minimise the significance of working within a team where staff support each other, and also having someone senior to ensure the team is unified.' (RMN 3)

'So, I would nominate somebody who would oversee the implementation. So that would be one thing that I would want to see in practice.' (RMN 9)

Interestingly, RMN 2 was able to compare and explain PBS practice from working on two different wards:

'PBS was implemented successfully in one particular ward where I worked, and this is because staff believed in the intervention. The ward was also well run, with very clear and strong guidance from senior colleagues. When I was transferred onto a different ward, although PBS was advised this never was a success. We need people to lead, but also to have a top-down approach as much as a bottom up strategy.' (RMN 2)

'A PBS plan also helped to bring back responsibility to the service user because they would take ownership of their care.' (RMN 9)

'Plans need to be communicated properly not just amongst staff but more importantly with service user, patients and carers. It's so important to get people on board… in particular, patients.' (RMN 8)

Leadership required assuming roles and key responsibilities, including bringing people to work together to improve the care of service users:

'Leading will entail much more such as the formulation of PBS, working together and bringing people together for the best interest of service users.' (RMN 4)

'When there is a paperwork regarding PBS it is better for all of us to sit and discuss, including psychologists, nurses… to sit and talk.' (RNLD 12)

'It is all written; it is typed and printed. there are also pictures, and it is done in an easy read style. The patient will have a copy, staff will keep a copy as well… we have

got a folder where all the PBS plans are kept for reference and handover between teams.' (RNLD 11)

'There is something important lacking – the right attitude.' (RMN 14).

'You should not let anything stop you from implementing things like PBS because it's part of the care package we manage.' (RMN 14)

'This creates the link that helps with the co-ordination and prevents any breakdown in PBS care. We also provide a lot of support to the provider.' (RMN 17).

It should be observed that participant RNLD 12 describes challenges with management:

'At the first meeting they were present, but I think what I'm saying is that there is an issue with the overall management in the organisation, because sometimes… when they come….' (RNLD 12)

5.3.5.2 Sub-theme: MDT Approach

An MDT approach was a sub-theme mentioned by most nurses. In the context of PBS, the formation of an MDT within mental health services was significant to them for the long-term treatment and rehabilitation of service users. They stated:

'Psychologists have to work closely with others, including nurses, as we are the ones who are with the service users most of the time. So, we are important in this process. Nurses need to be consistent with PBS approach too. A lack of consistency and poor communication can become barriers in PBS overall.' (RNLD 5)

'*This is not to say that nurses cannot do the same [be involved at that level] … and I think it has to be a team approach.'* (RNLD 7)

'So, we have PBS discussion every two weeks. This is where the whole MDT meets to discuss PBS implementation on the ward. Ward staff attend.' (RNLD 11)

It was established that interactions and engagement between professionals, carers and service users was indispensable for the good functioning of PBS.
RMN 4 expresses it as:

> *'Communication between different professions, service users and staff, and carers, [and] family members are very crucial in the implementation of PBS. We cannot have a system whereby one person decides, and then there is no consultation, no discussion or exchange of ideas, views and opinions with others. Good communication brings consistency and reinforces the validity of the intervention.'* (RMN 4)

The success of PBS was found to depend on several factors, including effective multi-professional teamworking:

> *'The MDT agrees to a plan of how we support service users with challenging behaviours, so then PBS works well.'* (RMN 1)

> *'Having the input of different stakeholders would make the plan a bit more robust, but….also ensure the fulfilment of the plan.'* (RNLD 10)

> *'Also, making sure that nurses are working in collaboration with everybody else, including psychologists and medical doctors, so that there is a full MDT approach to the implementation of the framework.'* (RMN 9)

> *'We need stronger collaboration. Every time when the psychologist wants to do something, they must have a small meeting with the nurses, before they even go to the patients… and also to involve the patients more in their care.'* (RNLD 12)

Staff from LD services seemed to work in unison when facilitating PBS. RMN 2 claimed:

> *'Furthermore, in learning disability services, where PBS is widely used, there seems to be better coordination and more team effort, with the right attitude from the team.'*

(RMN 2)

Participants described the value of MDT functioning in relation to PBS:

'I think I would need the support from MDT to start with. MDT is very hierarchical… to certain extent. So, we need to change the way MDT functions.' (RNLD 6)

'Nurses have the background that could be useful in the implementation of PBS and psychologist would need to embrace that knowledge and work together.' (RMN 9)

'Quite useful to hear from different disciplines and expertise that people were using PBS in many different ways with their clients, so that was quite good.' (RNLD 11)

*'…but I think nurses or other staff could lead the project and being supported by a team.' (*RMN 15)

'…in planning those strategies, and therefore it's so important that you involve with others.' (RNLD 19)

In summary, the participants referred to communication as an essential element in delivering PBS. They identified leadership as a substantial element, alongside collaborative working. The next theme to emerge was 'effectiveness'.

5.3.6 Theme 6: Effectiveness

The sixth and last theme to emerge was 'effectiveness of a new construct', incorporating the sub-themes 'multi-component', 'reduces challenging behaviour', and 'appraising a new construct'.

The effectiveness of PBS was narrated thus:

'…with PBS it's about looking at the bigger picture and…how we can, as nurses, as support workers, get to understand the client and see how our actions, and how the environment, interacts with that client.' (RNLD 6)

'It is supposed to be supporting the individual rather than being punitive or infringing on people's human rights.' (RMN 9)

And went on to say:

'PBS favours simplicity, in the sense that the language that is used is clear simple and it identifies the behaviours that needs to be addressed and it also provides 'how' as much as the 'when' and 'by who'. (RMN 9)

The nurses regarded PBS as a consistent and reliable approach that comprises different stages aiming to address behaviours that challenge:

'I think anxiety and fear around the unknown is something that needs to be addressed.' (RMN 9)

'There should be an overview of all concepts and PBS should not, as any other interventions, be used independently.' (RNLD 7)

'That's why the decommissioning of the seclusion room happened. So, PBS does really ***work'*** (RMN 14)

5.3.6.1 Sub-Theme: Multi-component

Participants referred to the effectiveness of PBS as a multi-faceted approach. RMN 1 described PBS as a framework consisting of various positive interventions:

'What I think; caring for someone with behavioural problems, challenging behavioural problems, I think you can have other interventions with PBS. PBS does not solve all the problems of challenging behaviour because what I understand is that PBS is a multi-composed framework, and it should be used alongside other interventions for it to become effective.' (RMN 1)

RMN 3 said:

'With time we have learnt and understood that PBS is a framework that entails several interventions. One example is for staff to have a good understanding of

challenging behaviour and few practices that engage service users in meaningful activities.'

Participants identified PBS as a framework that worked well when there is good understanding of its features. They commented:

'Going back to the original question: staff appreciate that PBS is not just one practice. It consists of a series of practices, but also of staff being mindful of a number of factors that contribute towards successful implementation of PBS. It is a package, isn't it?' (RNLD 5)

'PBS is quite effective but there are other interventions, or models of intervention, that could be equally useful in challenging environment.' (RNLD 10)

'I do not think PBS on its own is enough to achieve objectives. There is always need to have person-centred approach to care, and PBS provides that.' (RNLD 7)

'There are other interventions that could also be used. A wide range of tools are already available on wards. Working as a team is significant for any framework to work.' (RMN 8)

'Have, like, being able to try and apply the strategies at home…' (RNLD 18)

5.3.6.2 Sub-Theme: Reduces Behaviour that Challenges

Many nurses have found PBS a reliable intervention by which to achieve that aim. RNLD 5 contended:

'For me, PBS is an effective way to address challenging behaviour – not sure if it is the only way, but it certainly works with many individuals. In the case that I cited earlier we have seen that PBS had decreased restrictive practices… less challenging behaviour.'

RMN 4 felt confident about PBS and described its positive effects on service users:

'PBS has been a very useful tool to help patients deal with their behaviour, like challenging behaviour on the ward… and helping patients to kind of change behaviour which is hard to deal with. PBS is a kind of a plan to help patients move on in their care.' (RMN 4)

PBS was recognised as a useful framework in situations where there is a history of challenging behaviour, and additionally in cases where potential risks of developing such behaviour are present. RMN 2 argued:

'Of course, with challenging behaviour it is more useful but it causes no harm for everyone to have one. Particularly with service users who can potentially become challenging.' (RMN 2)

RMN 1 and RNLD 7 discussed the effectiveness of PBS in supporting a service user with complex needs during which the framework helped produce the desired outcomes:

'If I could remember, we used PBS with one of our clients. This client had very challenging behaviour. He couldn't engage, and he always wanted everything to be done promptly, so it became a problem; but after having a meeting with the MDT there was a plan that came up. There was a positive behaviour plan that was suggested which we tried, and it worked.' (RMN 1)

'PBS is a very useful framework that works really well in specific situations.' (RNLD 7).

Participants felt that PBS consisted of a system that rewarded service users; that motivated them and incentivised good behaviour: Two nurses (RMN 3 and RMN 4) said the following:

'The positive thing is that service users enjoy music, they like to go out; so, it is about getting them extra community leave. They have one community leave as it is, may be getting extra community leave as long as they behave.' (RMN 3)

'We get the patients to sign the chart, as a signature is required, at the end of the shift for good and bad behaviour. And if behaviour was not positive then the chart is not signed, which eventually means the service user will not get a reward.' (RMN 4)

Behavioural charts were mentioned by RNLD 6. She felt them integral to PBS practice:

'So, we had a signature chart, whereby each and every time he [service user] behaved himself he would receive a signature per shift. So, each and every time there was no shouting or swearing, they would sign to say that he has been good. He knows if he gets around twenty-five signatures then he will be rewarded with something that he likes. One of these rewards could be money towards a trip or for something he wanted to purchase.' (RNLD 6)

The provision of rewards was a way of positively reinforcing good behaviour as stated by RMN 2:

'On ward there was a general lack of interest in PBS, but the practice was linked to service users' rewards such as having leave etc.' (RMN 2)

'Behaviour modification' emerged as a sub-theme, mentioned by nurses RMN 3, RNLD 6 and RMN 4. The analysis from RMN 3 was on the use of PBS in cases where certain unwanted behaviours were identified:

'I think what I have come across is that it is good to start very early, you know, once you see someone behaving in an irrational way. It is good to start immediately not to leave it late.' (RMN 3)

As stated by RNLD 6, PBS was applied in cases where service users were verbally abusive, and the practice was deemed helpful in addressing these concerns:

'So, my first and proper use of PBS was [a]ward where we had a patient who, by the way he deals with demands, and asking for things is usually by shouting and swearing.' (RNLD 6)

RMN 4 confirmed this:

'So, for me it's been a very useful tool to help patients deal with their behaviour [of concern] on the ward, and helping patients to kind of change behaviour which is hard to deal with.' (RMN 4)

It was clearly often the case that a reward system is included in PBS plans. The participants talked about the usefulness of the tool in behaviours that challenge:

'*There are examples of violence, aggression and other restrictive interventions that can be avoided with the effective use of PBS.'* (RMN 14)

'PBS is about improving quality of life as not everybody displays behaviours that challenge.' (RMN 14)

'This approach is proper centred to that person who is at risk of behaviour that challenges or any other disruptive behaviour.' (RMN 16)

'I would say it's a good tool to use for children with learning disabilities and autism, and behaviour problems.' (RNLD 18)

5.3.6.3 Sub-theme: Appraising a New Construct

PBS was a relatively new framework in some areas of care:

'PBS could well be relatively new approach that would need to be evaluated and appraised before staff could embrace it.' (RNLD 7)

'While PBS remains a new concept, it needed proper training for staff to familiarise with the model.' (RMN 8)

There is optimism that PBS could be useful in community services, while there is on-going discourse:

'I accept that PBS could be useful in the community given the presentation of many of our service users.' (RMN 9)

'Where does it come from and why has it to be implemented in such a way…' (RMN 9)

As a new construct for many nurses, the full impact of PBS is still being evaluated by some practitioners:

'This is new to many of us. We are still learning a lot about it and I think there should be continuing support in this journey.' (RNLD 12)

Nurses appreciate and value the on-going support provided to better understand PBS and its application:

'I value the informal discussion because staff is more receptive, and PBS is put into context, which is the practical aspect of the new model,' (RNLD 11)

'While PBS remains a new concept, it needed proper training for staff to familiarise with the model. Staff were using PBS without any particular thought. Therefore, the full effect of the model wasn't felt in areas where there was no training.' (RMN 8)

'Moreover, not enough is being done to raise awareness.' (RMN 14)

'You cannot expect everybody to be aware of PBS.' (RMN 14)

'Some staff did not see the importance of PBS and also in some cases it being something new to the ward and not being used before.' (RMN 15)

The participants described PBS as an effective and supportive tool in situations of behaviours that challenge, and the framework supported service users to progress their care pathways. PBS was a useful practice in areas where behaviour was an issue. However, nurses have also suggested that PBS was composed of several elements that focused on different aspects of the individual; this new approach that is being appraised.

5.4. Conclusion

This chapter has discussed and presented the study findings in relation to the first construct, second construct, sub-themes and the six distilled themes. This section has provided analysis and interpretation of the study while it has included direct quotes from all nineteen participants. The six themes that emerged were individually explored. Each theme generated two sub-themes. The next chapter offers a discussion with reference to the findings and preceding chapters.

6.0 Discussion

6. 1 Introduction to chapter

This chapter is underpinned by the preceding chapters to present the following discussion. My study has collected new PBS knowledge that contributes to the existing evidence base. A literature review (see 3.6.1) identified a gap in the current evidence base regarding nurses' experience, as a distinct professional group, of PBS. Section 4.6.4 contains details of the nineteen nurses (n=19) who participated in addressing the gap in current literature about nurses' experience of PBS. Therefore, my research is premised upon the knowledge that it is the first of its kind in a mental health organisation. This chapter, therefore, presents the discussions on the findings of my study, with existing literature contributing to the contemporary evidence base concerning PBS. Six themes emerged namely training, resources, psychology-led practice, restrictive interventions, communication, and effectiveness of a new construct. A reference list of first constructs can be found in Appendix 14. The conclusion will demonstrate how this study has contributed towards existing knowledge and originality.

6.2 Training

Training is a constant and consistent theme that emerged from the data and is discussed in Chapter 5. Training, as a theme, is consistent with findings from the literature review (see 3.6.2) where it became evident that staff find PBS training useful in gaining knowledge and in changing their attitude. All participants from my study strongly emphasised the importance of suitable PBS training to increase awareness of the framework. The nurses have depicted training as fundamental for the effectiveness of PBS, particularly towards maintaining consistency in the care of individuals with behaviours of concern, and in developing strong therapeutic relationships with service users. While training is viewed as an essential component that enhances confidence, it gives nurses authority to lead and facilitate the delivery of PBS. However, PBS training requirements may vary depending on clinical environments, and mental health practice may differ from a learning disability perspective as illustrated by RNLD 10 and RMN 13 (see 5.3.1).

In this study, many participants (n=15) described a lack of structured and appropriate PBS training at local level, and they expressed a desire for further training on the subject. However, all participants (n=19) claimed to have gained PBS experience through their day to day clinical work and in-house training. Nonetheless, the necessity for structured training,

education and professional development opportunities in PBS became an overarching theme in this study. For example, participant RNLD 10 (see 5.3.1) succinctly described the difference in the effectiveness of in-house training and the journey to becoming a PBS expert, while RMN 13 urged parity of esteem between learning disability and mental health wards regarding PBS training, albeit in house.

> '*We are a mainly yeah, we are in mental health trusts. OK, we have learning disabilities as well, especially in forensics… but we have a ward there, but it should be geared more towards mental health.'* (RMN 13)

Many participants including RMN 2 (see 5.3.1.1) suggest that, though PBS was being practised, there was no trust-wide substantive PBS training apart from some internal awareness sessions.

Those in-house sessions were designed by clinical psychologists to create PBS familiarity so that nurses could appropriately use the framework. Most nurses not only expressed a desire for advanced PBS training and awareness, but also depicted how clinical psychologists have supremacy on the delivery of PBS, and participants felt clinical psychologists have the prerequisite to lead PBS, as argued by RMN 17.

'So, psychologists have the training and their background helps their position within PBS.' (RMN 17).

Participants' narratives also referred to the important fact that training correlates to confidence and the authority to lead PBS in practice. Many participants (n=13), as illustrated by RMN 3 (see 5.3.1), have reported a lack of in-depth and suitable PBS training during their pre-registration nurse training, followed by limited input during their professional journey.

Concerning their experience of the framework, most nurses (n=15) held a view that training was key to the success of PBS, the benefits of which are evidenced in existing literature (Allen *et al.,* 2005; MacDonald and McGill, 2013; Stocks and Slater, 2016). Although nurses are involved in supporting service users with PBS plans, many, (n=15) in my study, felt they did not have an adequate level of PBS knowledge, nor have the necessary comprehensive exposure to the actual value of the framework, as explained by both RMN 1 and RMN 14 in section 5.3.1.

Nurses' involvement was mostly supporting the behavioural support plans in place and communicating with their team via the reporting systems available. A lack of training undoubtedly influenced nurses' position on PBS, resulting in them not taking on a leading role. This finding identifies a gap in the current evidence base as it positions nurses as being at a disadvantage in the field of PBS. I found that the required skills, knowledge, and a good understanding of PBS that builds confidence for leadership in PBS practice were lacking both in practice and in literature. Hence, an absence of confidence from many nurses partially explains the leading role that clinical psychologists have embraced, and the nurses' deficit in authority to lead PBS has become evident. This scenario may elucidate that while clinical psychologists have become the main drivers of PBS, nurses are relegated to a secondary position, which is compounded due to a lack of training; fewer opportunities exist for nurses to be considered on equal terms with clinical psychologists. This is relevant because, as argued before (see 2.4), nurses are often at the forefront of behaviours that challenge (Itzhaki *et al.,* 2015) and hence should take centre stage in PBS practice. Further, PBS training enhances nurses' competence, skills, and knowledge to deliver effective care. Therefore, the nurses I interviewed advocated for PBS training during pre-registration and on-going post-registration support, an argument that is supported by my literature review where it is clear that PBS training is essential for the advancement of PBS (see 3.6 and 5.3.1.1).

Correspondingly, Stocks and Slater (2016) have highlighted concerns regarding PBS training for frontline health care professionals in general, citing that it remains at a basic level across health organisations (Table 3). This situation inevitably affects the care delivery in areas of challenging behaviour and the support, or lack of support, that patients receive as a result. However, in a rare configuration where there is consistent and reliable PBS training, it is observed to have produced a notable increase in staff confidence (Stocks and Slater, 2016). In my study, it became noteworthy during the interviews that a high majority of participants (16 out of 19) had not had formal (i.e. BILD) PBS facilitator training apart from bespoke awareness sessions offered locally. BILD training is delivered over five days and is quite intensive compared to an internal model. Indeed, there is a relevant cost implication for a BILD certified training compared to in house awareness sessions.

I agree with Ager and O'May (2001) who contend that the efficacy of PBS is dependent on the knowledge and skills of the staff implementing it. My study has evidenced this through the participants' experience via data analysis and findings (see 5.2). Nonetheless, the optimum or ideal structure of any PBS training remains unclear and undecided. Likewise,

there is a lack of evidence reporting on the composition or programme of PBS training appropriate specifically for mental health services. Although Stocks and Slater (2016) have identified some positive outcomes of PBS training, namely knowledge and attributions, there is no verification of how this translates into practise nor the impact it has on the service users' acuity of challenging behaviour following training. It is argued how PBS training that emphasises challenging behaviour and its ethics are valuable in the long-term care of service users (Grey and McClean, 2007; McClean and Grey, 2012). Findings from my literature review (see 3.6.1), together with my wider reading on PBS, suggest that when staff are appropriately trained in PBS it influences their attitude and improves staff confidence in difficult situations (Rose *et al.,* 2014; MacDonald and McGill, 2013; Lowe *et al.,* 2007; Wills *et al.,* 2013). While it seems to be a two-way approach, PBS training in some cases is found to greatly improve staff awareness of challenging behaviour (Lowe *et al.,* 2007; McGill *et al.,* 2007). The participants (n=19), in my study, value training as a major factor that would help nurses and other colleagues become competent and confident in PBS.

The provision of training to a workforce has cost implications and involves using a multitude of resources such as releasing staff to attend workshops, identifying appropriate training agencies, and the involvement and collaboration of different stakeholders (Atkinson, 2018). The NHS is already financially stretched; therefore, any proposal for externally acquired PBS training may prove inaccessible at present (Gyllenberg *et al.,* 2018). Despite the evidence in favour of PBS training, many health organisations may struggle to meet this need due to financial pressures that impact an already under-resourced mental health service (Sully and Bowen, 2012). To complicate matters, there does not seem to be specific guidance advising on the shape and form of PBS training that would support the design, delivery, and evaluation of the model (Atkinson, 2018).

In the absence of adequate PBS training, my study has found a heavy reliance on past clinical experience, local-level awareness training and prior [brief] exposure to PBS by which nurses find themselves relating to the framework. In my study, many participants (n=13) became aware of PBS after becoming registered nurses, whereas for others (n=6) it was during nurse training, even though PBS was not a formal aspect of their nurse education curriculum. Nurse pre-registration exposure to PBS training in this situation facilitated basic awareness (i.e. training that did not cover functional assessment) which did not necessarily prepare the students to become confident PBS facilitators. Therefore, there is an argument for PBS to be part of pre-registration training to prepare the future workforce (Hext *et al.,* 2018). Evidence suggests that, despite staff rating PBS training as being very good in services where

it is offered, only 30% of all PBS plans could be classified as high-quality and meeting the features of PBS (Hassiotis *et al.*, 2018; Atkinson, 2018). This may indicate that the model and delivery of PBS training needs to be reviewed to increase focus on the practical constituent of the framework rather than merely the theoretical element. Some practical skills of PBS are the undertaking of a functional assessment and the design of PBS plans (Ham and Davies, 2018). This point is articulated by RNLD 6 who talked about the 'extensive and practical' (Appendix 14) requirements of PBS training.

The PBS Coalition has developed a PBS competency framework (http://pbsacademy.org.uk/wp-content/uploads/2016/11/Positive-Behavioural-Support-Competence-Framework-May-2015.pdf) that supports service providers in maintaining the standards of PBS (PBS Coalition, 2015). The framework lays great emphasis on the correlation between staff welfare and PBS (PBS Coalition, 2015). However, none of the participants in this study referred to the PBS competency framework; therefore, accessibility to these already available resources needs addressing. While training is an indispensable criterion for the success of PBS, staff welfare is equally significant to achieve a safe and therapeutic clinical environment, especially when staff burnout is one of the reasons that explains their poor interactions with service users (Skirrow and Hatton, 2007). This indicates that PBS training should endeavour to improve relationships, communication between different stakeholders, stress management and evidence-based practice (Webber *et al.*, 2017). This aspect is commented on by RMN 9 (see 5.3.1).

There is evidence of a link between PBS training and staff attitudes (MacDonald and McGill, 2013; Hastings, 2010; Davies *et al.*, 2015). My study shows a connection between training, confidence, and attitude towards PBS (see 3.6.2). However, training, albeit essential and useful, is not on its own sufficient to bring the changes that the nurses expressed a wish for; positive attitude is identified as a keystone to the success of PBS (Dench, 2005; Price *et al.*, 2018a). This reflection is made by RNLD 5 (see 5.3.1.1) who said addressing a lack of interest from nurses could be an important factor in advancing PBS.

For these reasons, nurses' attitude is a barrier that proactively needs addressing, and I would advocate that a supportive supervision process and ongoing appraisal are implemented.

Correspondingly, it has been established that classroom-based PBS training has minimal effect on staff knowledge and competence (Lowe *et al.*, 2007). Hassiotis *et al.* (2018) suggest PBS training does not reduce challenging behaviour unless there is a shift in attitude. This is supported by Padden (2016) who claims that staff attitude is greatly

influenced when there is a variety of teaching styles with a practice-driven approach (Padden, 2016). Therefore, in a PBS context, my study supports existing evidence in suggesting that in addition to tailored training, the right professional attitude, and commitment to deliver PBS are critical. RMN 4 articulated it in section 5.3.2.1.

PBS training is not pertinent solely for nurses but is equally valuable to other colleagues as equal partners, such as nursing associates, graduate mental health workers, doctors and nursing practitioners who are all part of the MDT. Hence, the argument is made to push for across the board mandatory PBS training that is delivered in a manner that helps change attitude and culture. Both RMN17 and RNLD 12 made this point in sections 5.3.1.1 and 5.3.2.1.

It is argued that PBS training can contribute towards a culture change where there are fewest restrictive interventions together with the provision of suitable long-term recovery support to service users in challenging environments (Stocks and Slater, 2016). While the availability of training opportunities is a major element that could decide the fate of PBS, it is equally important to create a practical awareness of the practice. Clinical psychologists are found to be key players in supporting nurses with the delivery of local awareness training within the NHS organisation, as argued by RNLD 7 (see 5.3.2.1).

However, in the quest to source external training, as it seems to be the preferred option from the nurses, health organisations (including mine), is the need to be mindful of the quality of training commissioned (PBS Coalition, 2015) and whether the level and type of training offered suits the training needs of frontline staff, especially those working in challenging wards (Embregts *et al.*, 2017). One difficulty that NHS trusts seem to face is a lack of interest in PBS mainly due to a disregard for practical aspects of the framework, as well as a lack of service users' involvement in its delivery (Ham and Davies, 2018). It is suggested that, at this time of flux, the care system needs to reinforce service users' participation in training and in all aspects of their care (Hennessy, 2017). Staff are unlikely to enthuse about PBS if the concept remains obscure or unknown (Cox *et al.,* 2015) as mentioned by RNLD 6 (see 5.3.1.1).

Embregts *et al.* (2017) claim that PBS training should be delivered by professionals from local, regional, or national agencies who have significant expertise. This is in line with the argument that successfully passing a functional assessment in PBS would necessitate well-informed and well conveyed input (Dunlap and Kern, 2018). There are a few university-based training programmes on PBS, which could potentially be commissioned by health care organisations. However, while these courses have recently been introduced, there exists the

issue of whether health organisations have enough nurses and staff accessing them. University-based courses tend to be expensive and health organisations may struggle to release staff into such training against the backdrop of severe cuts in healthcare budgets (Sully and Bowen, 2012; Padden, 2016).

My study found in-house training to be an essential element for nurses to become sufficiently competent to pave the way towards gaining the authority to lead PBS practice. It also highlights the inadequacy of the present structure that prevents the workforce developing skills. Training, when delivered in a well-thought-out manner, has the potential to influence the care in areas of challenging behaviour. Additionally, and most importantly, my study reinforces the theory that PBS training has the potential to enhance service users' quality of life and improves therapeutic relationships between staff and service users. Reasons why a co-produced training model of PBS is highly favoured are a topic I have developed with a local university and discuss further in Chapter 7. It was also clear from the interviews that nurses have been encouraged to question their attitude and interest in PBS through participation. In this way, my study has offered a new understanding of nurses' experience of PBS from a training perspective.

6.3 Resources

The findings from my study revealed that teamwork (further discussed in 6.3.5) and consistency are essential components in the delivery and advancement of PBS. Therefore, given the current climate of staff shortage (Buchan *et al.,* 2020), any long-term PBS objective could be greatly compromised if the recruitment, retention, and development of nurses remain problematic. The success and consistency of PBS were shown as dependent on the presence and input from skilled staff with the values and, commitment as described by two of my participants (RMN 2 and RNLD 12- see 5.3.2.1).

> *'I don't know – maybe it was something to do with time management – resources were of issue. There were issues around staffing as well.'* (RNLD 12)

Resources are greatly affected by high staff turnover. Nurses who work in challenging environments tend to leave their job prematurely compared to peers from other clinical settings (Cleary, 2004; Slemon *et al.,* 2017). The staffing problem is a nationwide phenomenon. According to the RCN (2017a), the UK nurse shortage crisis is real, as the number of students entering nurse training needs to improve and the number of individuals

leaving the profession is on the rise (House of Commons Health Committee, 2018; Kings Fund, 2019; West *et al.*, 2020). Incidentally, with the advent of new policies regarding the abolishment of nursing student bursaries, a further reduction of nurses was expected, and the effects are already being felt (Moore, 2017; House of Commons Health Committee, 2018). In the current context of the Covid-19 pandemic, although there has been an increase in the intake of nursing applications, the nursing staff deficit appears unchanged in the fields of mental health and learning disability (Buchan *et al.*, 2020). The current struggle to recruit and retain registered nurses in the NHS is intense and having long-term effects on the health care system (House of Commons Health Committee, 2018; Both-Nwabuwe *et al.*, 2018). Inadequate resources directly influence evidence-based practice such as PBS. From a local perspective, in my current role I find constant staffing pressure and lack of resources as a major challenge that affects the implementation of PBS particularly as systematic, consistent, and organised implementation is of the essence (Padden, 2016). This argument is reflected in evidence that illustrates the importance of appropriately trained and committed staff to work in challenging environments (Bowers, 2014; Bowers *et al.*, 2016). Also evident in healthcare organisations is a lack of careful distribution of skilled nurses giving due consideration to skills and skill mix, gender mix, and competences (Both-Nwabuwe *et al.*, 2018), which advocates for the formation of a skilled workforce. However, although higher numbers of nursing staff would be welcomed, quality of care and outcome is not solely dependent on the right number; the skills, values, attitude, and behaviours of a workforce are essential for the success of any care model. The NHS England (2014, page 29-30) puts it:

> *'We can design innovative new care models, but they simply won't become a reality unless we have a workforce with the right numbers, skills, values and behaviours to deliver it.'*

A call for uniformed approaches towards PBS implementation is revealed by my study, as demonstrated by RNLD 7 (see 5.3.2.2).

6.3.1 Leadership

Many nurses (n=6) in my study, as supported by Ockenden *et al.* (2014) and the PBS Coalition (2015), ask for team consistency and strong leadership for PBS to work. However, the PBS competency framework (see 2.5.1) proposes three methods of implementation: through an individual practitioner leading the process; through a team approach; or through a system-wide structure. Irrespective of the methodology, the risk of failure is real if basic

resources are not available (Buchan *et al.,* 2015). As mentioned by RMN 9 (see 5.3.2), adequate staffing remains a priority, even more so in the current context of Covid-19 where the use of restrictive interventions has increased (WHO, 2020). Similarly, RNLD 5 (see 5.3.2.2) identified consistency as fundamental to the successful delivery of evidence-based practice including PBS.

I am of the view, as informed by the findings of this study, that an alignment should be achieved between consistency in practice and practice leadership for PBS to be successful. This argument is missing from current literature on PBS although, in general, Toogood (2017) supports the idea of the visible presence of leaders who champion change and improvement. My findings suggest that nurses want the opportunity to develop leadership skills and more clearly defined capabilities to work in areas of challenging behaviour, so that, with that required training, nurses can lead PBS in future. However, as captured by RMN 1 (see 5.3.2.1), it is imperative to understand the reasons why key professionals, such as clinical psychologists and nurses, are arguably not working together. The leadership resources referred to by RMN 1 (see 5.3.3.2) are key for the advancement of PBS and a path to ensuring nurses are supported in the delivery of the framework.

6.3.2 Workforce

The central resource of qualified and suitably skilled staff is an essential influencer in the delivery of PBS, alongside consistency in approach. In their quest to develop and support nurses, a pan-London initiative was initiated involving apprenticeship schemes that provide opportunities for experienced health care assistants to further their skills, competence, and knowledge. This enterprise is valuable for the advancement of PBS because within organisations, including my own, many health care assistants have encountered PBS during in-house awareness sessions and will have used PBS in practice, albeit at various levels. This prior PBS experience is vital for a professional development that could encourage the emergence of future PBS leaders. In fact, to make progress, NHS leaders must have a collective strategy to make PBS training accessible to the wider workforce, so that the framework is not restricted to registered nurses and clinical psychologists. This was echoed by RNLD 12 (see 5.3.2.1).

The participants in my study wish to be well-informed in PBS but have also expressed a need for the whole workforce to be skilled, including healthcare assistants, to provide PBS continuity. Although a wide training provision has cost implications it is nevertheless a

significant and useful investment, and a show of commitment towards addressing restrictive interventions in care settings (Walsh *et al.*, 2018).

As for staff shortage, my study indicates that adequate resources are essential prerequisites to ensure the effectiveness of PBS. There is currently an acute nurse shortage, and no research has yet highlighted its impact on PBS. This is best described by RMN 14 (see 5.3.2.2).

The success of any evidence-based intervention, as mentioned above, requires more than mere training or a certain quota of staff. RMN 14 referred to the importance of substantive staff who can develop rapport with patients and, hence, implement long term interventions.

As regards the nursing workforce at a local level, my findings suggest that mental health organisations, including mine, need to review their policies and strategies regarding recruitment and retention. Further, a safe work environment where there are the fewest possible restrictive interventions may help staff recruitment and retention. Such a safe environment could help increase the attraction of nursing and address the severe shortage of registered nurses in practice, alongside the nursing students' maintenance grant introduced since September 2020 (RCN, 2019b). However, in the field of mental health, there has been historical underfunding over many years (United Nations, 2020; Rosen *et al.*, 2020), meaning that organisations have struggled to support health care workers undertaking their nurse training. An extremely under-resourced mental health service may lead to vulnerable service users missing the appropriate and beneficial care of evidence-based practices such as PBS, which may have created a vacuum in the care system (Bannister, 2021). This vacuum potentially has direct effects on PBS, facilitating fewer opportunities to support individuals with behaviours that challenge (Bannister, 2021).

6.3.3 Recruitment and retention

The UK policy 'Safe and Effective Staffing: Nursing Against the Odds' (RCN, 2017a, and Buchan, 2019) have accentuated the challenges around the recruitment and retention of nurses. Capital Nurse, a London-based organisation funded by Health Education England (HEE), has advised that the recruitment and retention of nurses in London remain predominantly problematic (Buchan *et al.*, 2015; 2020). While the Health Foundation (Buchan *et al.*, 2020) has indicated an increased number of nurses joining the profession since 2017 and 2018, there remain major concerns for the fields of mental health and learning

disability (Buchan *et al.*, 2020). This is a relevant challenge as the participants in my study were from London where the impact and acuity of staff shortage are evident.

> *'There are problems in most of the services where we are thin on the ground.*' (RNLD 7)

Challenges will persist for the delivery of PBS if staff resources remain unchanged. Correspondingly, Karger *et al.* (2018) from my literature review (see 3.6.1), indicate that adequate staff support is imperative for PBS to succeed. My study illustrates the link between the current staffing situation and the risk of PBS being pushed aside in the face of other competing priorities in health care. Arguments about skilled staff resources present a clear demonstration of nurses' importance in the practice of PBS, one that my participants have consistently referred to, as evidenced by RMN 14 and RMN 15.

> *'With regard to PBS, it was not easy to implement especially with a shortage of regular staff- those who have rapport with the patients. We had a number of staff shielding, so we relied a lot on agency staff. They did not necessarily know about PBS.'* (RMN 14)

> *'We are short of staff… working with agency staff more, especially during the Covid pandemic. You have staff shielding and being sick. So, there's the argument that we haven't got enough staff so we can't implement PBS.'* (RMN 15)

Triggle (2018) and the Health Foundation (Buchan *et al.*, 2020) have described the NHS staffing situation as a national emergency. Figures published by the Health Foundation (2016) and NHS Improvement depict a severely understaffed NHS, a situation that is of grave concern in the care sector (NHS Improvement, 2018b; Buchan *et al.*, 2019). By 2024, it is envisaged that the nursing workforce would need to grow by over 40,000 to sustain demands (NHS Improvement, 2019). The severity of the situation prompted the RCN to propose that safe staffing in hospitals is made compulsory and protected under the law (RCN, 2019a). The arguments developed in this study call for concerted effort to improve staff recruitment and retention of staff through having appropriate leadership in place in order to preserve evidence-based practices such as PBS. Participants in my research have described resources as essential to the delivery of PBS. It is documented that a shortage of staff not only affects the experiences and care of service users; it is, indeed, a major contributing factor to burnout

and compassion fatigue (Jenkins and Elliott, 2004; Alenezi *et al.*, 2019; Montgomery *et al.*, 2019). These factors are why, as recorded in my study, participants have identified staffing as an important influencer in the delivery and effectiveness of PBS.

6.3.4 Learning disability and mental health

It became evident, as demonstrated in section 5.3.1, that participants from a learning disability background had a slight advantage of PBS awareness compared to those from the mental health field of practice. One experience is described by RNLD 10 (see 5.3.1).

As acknowledged in my findings, PBS exposure at a pre-registration level, while not enough to create experts in the field, certainly helped students in their endeavour to be informed about the model. Indeed, their experience proved useful in the appreciation of PBS in practice post-registration.

It is widely recognised that the majority of people with a learning disability are predisposed to mental illnesses (Clay *et al.*, 2012; Beavan *et al.*, 2011; NICE, 2018) and it is evidenced that this population group suffer from mental ill-health more than any other population group (Cooper and Van der Speck, 2009; NICE, 2018). Therefore, policies such as Valuing People (DH, 2001), NHS Long-Term Plan (NHS England, 2019) and the National Disability Strategy (2021) urge the support of people with learning disabilities who experience mental health problems through mainstream mental health services. My study findings have led to proposed actions for addressing the disparity between learning disability and mental health training, using PBS intervention to benefit this client group. Mental health nurses commonly provide care and support to individuals with learning disabilities, just as it is equally usual for learning disability nurses to work in mental health wards. However, it may be argued that current educational provision for both mental health and learning disability nursing students may fall short of equipping staff for inter-professional working (Donner *et al.*, 2010; Buchan *et al.*, 2019). In the field of PBS, and based on the findings of my study, my view is that PBS training should be embedded at pre-registration education in both areas of practice. The National Disability Strategy (2021) places further emphasis on the care of people with learning disability, who are often disadvantaged in the healthcare system (https://www.gov.uk/government/collections/national-disability-strategy-and-related-publications)

6.3.5 Teamwork

Teamwork is a sub-theme emergent from the main theme of ‘resources’. Foronda *et al.* (2016) contend that the positive outcomes of inter-professional teamwork surpasses status

and grades. While the benefits of MDT collaborative work are clear, there are nevertheless some barriers and complexities about this partnership. However, nurses remain key contributors to the partnership and are at the heart of the decision-making process alongside service users (Nibbelink and Brewer, 2018). Findings from my study correlate with existing evidence about nurses' perception of the supremacy and seniority of clinical psychologists and psychiatrists when it comes to decision-making about service users' care (Karben, 2011; Bailey, 2012; Eichbaum, 2018). This is illustrated by RMN 8 (see 5.3.2.1).

Collectively teamworking in a health organisation requires effort beyond a straightforward understanding of different roles and responsibilities; it demands mutual respect and professional acceptance. For instance, the effectiveness of PBS is informed by a process of collaboration and teamworking (Gore *et al.,* 2013; CQC, 2017). There are different ways of reinforcing teamwork but 'away days' are most common, where staff spend time outside the clinical environment to reflect, learn and build on the teamworking spirit (West and Markiewicz, 2016). However, as well as being a massive challenge to release staff to attend away days due to an already stretched workforce, there is insufficient evidence that away days alone deliver the required effect without an attitude of willingness to change (West and Markiewicz, 2016). Other opportunities to review and reflect on team performance present themselves through a reflective approach to team meetings where staff should feel comfortable and safe enough to evaluate their social interactions, performance, and team development; such meetings offer an opportunity to explore and improve teamwork (West, 2012; Royal College of Physicians, 2017). It has been common practice for individual disciplines to hold separate away days for improving team development (Royal College of Physicians, 2017). My study revealed a split between individual teams and suggests a lack of harmony as described by RNLD 5 (see 5.3.2.2).

These findings resonate with evidence suggesting various factors that influence inter-disciplinary working in the healthcare sector, particularly in complex health care environments (Morgan, 2017). Any uncomfortable atmosphere inevitably creates an environment where service users may not fully benefit from the care they are meant to receive, especially if treatment is not implemented collaboratively (Desai, 2016). This research has also indicated that nurses have reservations regarding the role of clinical psychologists in PBS implementation (RMN 3, 5.3.3.1).

Identification of such a hierarchy, and lack of inter-disciplinary engagement within an organisation, is arguably necessary to ensure high quality governance and accountability in a system where clear mutual expectations and respect between professionals is to everyone's

advantage. Understandably, each professional group has its own identity and code of conduct, but RNLD 6 (see 5.3.3.2) talked clearly about the dominance of certain professional groups.

To best address some obstacles posed by a hierarchical MDT, organisations could propose mandatory inter-professional team meetings and reflective platforms, conditional upon measures being in place to ensure a structured approach together with strategies to address the issues around resources (Baird *et al.*, 2020). This may mean different professions regularly connecting with the aim of building relationships and reinforcing collaborative working through reflection, case studies and real-life case discussion, while focussing on the patient interest agenda of PBS. It might be expedient to consider external facilitators for these compulsory team training events as they would have the expertise and distance to challenge attitudes, beliefs and professional barriers that hinder joined-up practice in healthcare (Brindley and Reynolds, 2011; Royal College of Physicians, 2017). This practice could well build and consolidate a team spirit in MDT, which is often best described as a product of different constructs comprising a sense of togetherness and a collective or shared commitment (Turel and Connelly, 2012). In the current Covid-19 pandemic, however, there is much reliance on the use of digitalisation whereby various meetings and training are delivered online.

6.3.6 Service users at the centre of PBS

The findings from my study are consistent with the literature (Kortteisto *et al.*, 2018; Weinstein, 2006) that identifies service user involvement and engagement as making them equal partners in mental health services. Service user engagement is particularly necessary for achieving effective treatment, intervention, and improved care. Any evaluation or review of treatment requires service user involvement that surpasses mere participation. Particularly in mental health services, due to previous cases of abuse, discrimination, and degrading treatment (see 2.2.1), it is essential that service users are part of the decision-making process about their treatment, including care that involves PBS. However, my study has identified an issue that imply the perception of a paternalistic approach in the way that PBS is being implemented (i.e. asked to sign reward charts at the end of shifts). Both RMN 3 (see 5.3.4) and RNLD 6 (see 5.3.6.2) referred to reward charts and signature charts.

The above interventions, described by the participants, may at times resemble the care of children with behaviour issues where a child is given a sticker for good behaviour. This reward technique may work well with children and is deemed quite therapeutic (Leijten *et al.*,

2019). In adult services, this approach needs to be reviewed so that individuals are treated with respect and not infantilised.

During analysis of my study findings, I observe that some participants valued the essence of co-productive approach, where service users lead care delivery and make decisions on approach, planning, design and evaluation of interventions and services; these are core components for a successful organisational shift towards consumer leadership. However, any involvement must be beyond a token effort, as emphasised by Lakeman *et al.* (2007). Nevertheless, service user engagement may be justifiably difficult to achieve in situations where individuals lack mental capacity, or when service users are acutely unwell, so affecting their ability fully contribute. In such cases, advocacy services should be considered. Flexible forms of alternative communication may be necessary for certain individuals including those with learning disabilities who, due to their developmental impairment and level of disability, may require various degrees and types of support (Ninnoni, 2019).

Empowerment of service users require an approach that captures all the elements that affect its realisation, whereas mental health services commonly use power and control to influence the care and treatment of service users (Clark *et al.,* 2020). Co-production and empowered service users are shown to be necessary for an organisational culture shift that displays a genuine interest in power-sharing and where every player is authentically considered equal and is treated respectfully. One way to approach this is by challenging organisational culture, attitude and power-sharing between professionals and individuals by placing lived experience at the forefront of care delivery where there is appropriate information exchange and a service user-led PBS practice. As evidenced in my findings, nurses would need to be empowered, accept, and promote a shared decision-making approach with service users, in line with the shared decision-making framework (NICE, 2021). Barriers to a service-user-led PBS may include their lack of information or the inability to exercise choices. Addressing some of these barriers would be a good starting point towards consumer-led PBS, reinforced service user involvement, and co-production within a health system that genuinely seeks to empower disenfranchised groups.

6.4 Psychology-led practice

Narratives from my findings depict clinical psychologists as PBS leaders, as highlighted by RMN 4 and RMN 17 (see 5.3.3.1). Thus far, this finding is not highlighted in my reading of PBS literature, including during literature review, and therefore my study has

identified a gap in the current evidence base. My participants felt strongly about PBS being a purely psychology-led practice, a situation that has several implications as evident from my study.

My participants' observations could be partly explained by the origin of PBS. It is argued that PBS was initiated against a psychological backdrop in both the US and UK (PBS Coalition, 2015, Carter *et al.*, 2011). Similarly, Bambara *et al.* (1994) epitomised the original use of PBS as driven by psychologists in school environments, thereby supporting teachers to provide for children with challenging behaviour. In section 2.5.1, I mentioned that PBS is derived from ABA, a psychological intervention, and it retains certain common characteristics which position it as a behavioural approach (Risley, 2003).

The fact that PBS emanates from a psychological framework may have created some resistance and challenges from nurses against endorsing the framework (as they might otherwise have done) as argued by RNLD 5 (see 5.3.3.1). There is a strong sense that psychologists should not dominate the implementation of PBS. My participants (n=16) asserted being essentially involved in monitoring PBS, but that the clinical psychologists held the prominent role in developing PBS plans. The perception was that PBS was delivered through a top-down approach with nurses at the lower end of the hierarchy. Interestingly, it is evidenced that nurses in general, as direct care staff, view clinical psychologists as an unknown group whose input in providing healthcare is uncertain thus affecting professional integration (Osborne-Davies, 1996; Eichbaum, 2018; Wood *et al.*, 2019). My study has indicated that nurses view clinical psychologists as occasional workers who come onto the ward for the minimum period but still have a huge influence on patient care:

> *'Currently PBS plan is designed by people who are not even on the ward and these people are clinical psychologist or speech and language therapist. Nurses do not have a lot of input in the design of PBS. Nurses become the staff group who and show the delivery of the plan when I think this needs to be looked at. We cannot have a situation where nurses need to obey because we can do a little more than that.'* (RNLD 10)

An understanding of collaborative working between nurses and other professions is crucial. While a difference in professional cultures could be one of the reasons for this separateness, there is also the effect of the complex environment in which different professions work (De Vries, 2016). RNLD 12 presented this argument in section 5.3.3.1.

Therefore, it would seem that clinical psychologists are regarded as occasional workers with indeterminate roles who have momentary contact with service users (Saar and Trevizan, 2007; Wood *et al.,* 2019). Undoubtedly, some of these observations have impelled nurses to think it was appropriate for clinical psychologists to work in partnership with the nursing team and alongside service users to co-produce PBS plans rather than working in silos. This is argued by RMN 17 (see 5.3.3.2).

Concerns are expressed regarding only one profession leading PBS. To achieve consistency in the delivery of the practice it is essential to consider the most appropriate individuals to lead PBS based on their expertise, skills, and leadership abilities. Moreover, my study supports an MDT approach as being helpful because sharing knowledge and expertise across disciplines is valued (see 5.3.2.1). A salient component in the successful implementation of the PBS framework is demonstrated by RMN 14 (see 5.3.3.2), who values a constant MDT presence in areas where it is being practised.

The above argument is supported by Nancarrow *et al.* (2013) and Webber *et al.* (2017) who believe PBS should be practised in a way that crosses interdisciplinary boundaries. Similarly, the findings of my research emphasise the importance of teamworking and the significance and benefits of working in collaboration with professionals from diverse occupations, particularly as clinical psychologists may have only occasional contact with service users. In general, nurses wish to be actively involved and, at best, lead interventions based on their day to day interaction with service users (Pazargadi *et al.,* 2015).

As discussed above, and illustrated by RMN 17 (see 5.3.3.1), it was found that the delivery of PBS remains psychology-dominated, therefore, psychologists have positioned themselves as the natural leaders. Some of the psychological input includes the planning, organisation, delivery, and provision of PBS awareness training, as well as being involved in the functional and bio-psychosocial assessments of individuals (Webber *et al.,* 2017). There is a perception that clinical psychologists may have the essential skills and competencies to lead a team of facilitators, and that they have the required proficiencies and knowledge to provide PBS training and ongoing support (see 5.3.3). The role of clinical psychologists in PBS, and recommendations for its development and delivery, are outlined below in terms of current national drivers for changes in England and throughout the UK.

One prerequisite of PBS, in challenging environments, is the involvement of a wide range of professionals and disciplines who assist with its implementation (Hieneman and Dunlap, 1999; Carr and Sidener, 2002; Patterson, 2016). Clinical psychologists have become important players in the field of PBS under their training, achieving academic credentials

such as doctorate qualifications (DClinPsy) and competence in undertaking some tasks including the facilitation of a functional assessment (Scior *et al.,* 2014). RMN 1 discussed psychological input in section 5.3.3.1.

Those clinical psychologists, who have had the opportunities to develop their competence, are well-positioned to apply advanced psychological philosophies in care settings and have become proficient in working at an organisational level, therefore demonstrating good leadership skills (Beadle-Brown *et al.,* 2012). While Beadle-Brown *et al.* (2012) makes this argument, there is evidence of expert nurses who have lead PBS at various levels in healthcare organisations and also demonstrated advanced skills, knowledge and competences through continuous professional development (Savarimuthu and Jung, 2021).

While the findings of my study position clinical psychologists as a professional group who have the required assets to lead and deliver PBS, they were also seen as having the leadership skills to further develop PBS; and, most importantly, they are supported by other MDT members (see RMN 2, 5.3.3.2).

Based on the above, I feel there is an argument for clinical psychologists to continue to hold an important role in the implementation of PBS. However, clinical psychologists need to seriously consider teamworking alongside other disciplines; thus far, there are concerns about the readiness of psychologists to engage with others (Jones, 2017; Wood *et al.,* 2019). It is essential to evaluate the relationship of clinical psychologists with service users compared to the rapport that nurses develop with them.

Equally, my literature review identified professionals other than clinical psychologists who are already involved in PBS including schoolteachers, social workers and occupational therapists (see 3.6.1; Perez *et al.,* 2012). Therefore, although my study showcases a psychological dominance of PBS it is evident that framework leaders incorporate other disciplines, as experienced by RMN 2 (see 5.3.3.1).

My study findings are in line with Perez *et al.* (2012), who established the importance of OTs in the implementation of PBS, in appreciating that challenging behaviour may be caused by many factors such as social challenges, sensory modulation challenges or skill deficits. The role of OTs is central to addressing these behaviours of concern and, correspondingly, OTs have positioned themselves in a leading role. Similarly, social workers have used PBS after their assessment (Leyba, 2010), and the role of speech and language therapists in PBS is now equally well documented (Webber *et al.,* 2017). It is nurses' position as leaders of PBS implementation that remains unclear. My study, therefore, brings forward

for scrutiny some barriers that prevent nurses from taking on a role of greater leadership in this area.

It is my view, based on these findings, that nurses need to embrace the PBS framework in order to feel a crucial sense of ownership with the concept. This vital step would empower nurses to take on a leadership role smoothly and realistically. In cases where PBS has been successful, staff have been notably committed to advocating for it, so improving chances for PBS to succeed through a collaborative working approach (Ham and Davies, 2018). If nurses are fully engaged with the PBS process, it creates an opportunity for their skills to be valued within the approach, leading to positive outcomes (Davies *et al.,* 2016). Nurses' reluctance is perhaps due to them being too subservient in the MDT structure, and frequently in conflict with the biomedical model of care (Grant, 2001; Santangelo *et al.,* 2018).

It is clear that nurses are active caregivers in the frontline of care delivery, managing situations, supporting service users, and hence often becoming victims of violence and aggression (Dickens *et al.,* 2012). For that reason, nurses need to welcome opportunities for empowerment and to engage in PBS organisation and administration from the start. It has been demonstrated that nurses and doctors are the least amenable in their attitudes to shared decision-making and joint working (Cohen, 2003; Braithwaite *et al.,* 2013; Wood *et al.,* 2019), perhaps due to nurses and doctors being so committed to developing therapeutic relationships with service users (the keystone of their professional identity) that they sometimes neglect their professional relationships with each other (Browne *et al.,* 2012; Amudha *et al.,* 2018). The evolving essence of the nursing profession means that nurses, no longer distant bystanders, have become central participants in the care of service users (Santangelo *et al.,* 2018). Clinical psychologists, by comparison, are generally observed to be more flexible to adopting collaborative working patterns compared with other professions; they have shown great leadership in the PBS field, which this may have side-lined nurses (McKenzie *et al.,* 2020), as mooted by RNLD 10 (see 6.4).

While other important factors affect and influence teamworking, some of the dominant themes are hierarchy, power and individual characteristics (Jones and Jones, 2011; Sims *et al.,* 2015; Fox and Reeves, 2015); it has been shown that nurses and clinical psychologists need to share responsibilities and become accountable in working collaboratively for PBS to succeed (Karger *et al.,* 2018).

A psychology-dominated PBS intervention, as reported by participant RMN 14 (see 6.4), risks resistance and disinterest from other professionals, in particular nurses. To address some of these issues, improved interaction within the team is pivotal, as well as socialisation

between various MDT members as they develop a clear set of aims and objectives. Attitudes, not only of nurses but of other parties in a team, must be service user-centred and based upon a compassionate leadership model within the organisation, as advocated by West *et al.* (2020). Doctors and clinical psychologists may subsequently be equal and accommodating in their roles, while nurses become empowered to be more confident and less subservient (Silva *et al.*, 2019). Professions other than psychologists are gradually emerging to take a lead in PBS practice, but not from within the nursing profession, as highlighted in the previous section. It is accepted that nurses are extremely skilled at building relationships with service users (Cockerton *et al.,* 2015), and these proficiencies are usefully deployed in supporting users of PBS. In my study, it became evident that improved engagement involving various professionals, including psychologists, could encourage nurses to become drivers and leaders in PBS. Moving forward it is of extreme importance that nurses take on these roles in the care of challenging behaviour, and systematic preparation and nurse training are necessary steps to bring about this movement. However, an important consideration is that nurses themselves need to take steps to make PBS integral to their skills and competence so the care they provide is inclusive of the principles of the framework. Due to current challenges of depleted resources and staffing, nurses will have to further their leadership skills so they can prioritise, structure, and take ownership of their development in PBS. The integration of associate nurses as registered practitioners, and graduate mental health workers, could mean these staff take on some responsibilities so that registered nurses could devote more time to lead PBS. This could ensure that the implementation of PBS has all the required resources.

As demonstrated above, my study has revealed the perceived supremacy of clinical psychologists within a healthcare MDT hierarchy. RNLD 6 explained how this supremacy is supported and encouraged by psychiatrists (see 5.3.3.2).

It is therefore unsurprising that clinical psychologists have considerable influence over the decision-making process regarding the course of treatment, intervention, and choice of therapy to endorse, and this applies equally to PBS (Karger *et al.*, 2018). A position of power and influence for clinical psychologists makes collaborative work strained between the different professions. From a general viewpoint, there is a real risk that professional rivalry may drive nurses to feel disenfranchised to the point that they subsequently either leave the job or take a passive role within an MDT structure (Best, 2019). Historically, nurses have felt a lack of professional power compared to clinical psychologists and psychiatrists (Townend, 2005; Buchan *et al.*, 2019). It is argued that one way of encouraging professional partnership within an MDT is through inter-professional supervision (Townend, 2005; Dallimore *et*

al., 2016). A supervision platform comprising nurses, psychiatrists, clinical psychologists, OTs, and social workers could enhance team collaboration to improve service users' quality of care (Davys and Beddoe, 2020). This style of supervision could only happen if the leadership exists to bring different professions together using the strategy of encouraging the MDT to work towards meeting service users' needs. This simple concept could be used to set a platform for inter-professional supervision. Despite known challenges around professional identities, professional socialisation and differences in professional codes, this strategy, as found by Hutchings *et al.* (2014), may have the potential to foster an attitude and culture where supervisees are supported by supervisors based on competence and skills rather than dictated by their professional affiliation. My personal experience of this concept relates to my time as a ward manager, supervised and managed by an allied health professional colleague. This arrangement enriched my understanding of another profession role within an MDT, and it was helpful to hear how the input of an allied health professional could support the role of nurses to the benefit of service users. In this context, a policy or guidance to support the realisation of this concept, making it an organisational strategy, could be helpful.

6.5 Restrictive interventions

The theme 'restrictive interventions' emerged from my analysis, together with the sub-theme 'challenging behaviour' and 'human rights'. The misuse of restrictive interventions in mental health services is a widespread worry (DH, 2014). Restrictive intervention is described here as a deliberate act that takes control of a dangerous situation. These interventions may include physical restraint, rapid tranquillisation medications, or seclusion.

Treatment of people through applying restrictive interventions as a punitive measure clearly breaches the values of human rights (Kinner *et al.*, 2017). human rights and their link with mental health have long been associated with dominance, power, control and restrictions (Cleary, 2003; Mead and Filson, 2017). This is perhaps why Foucault (1995) refers to power and knowledge as co-existent and complementary to each other (Mann, 2002; Polifroni, 2010). It is further argued that a desire to gain knowledge can transcend into power, with negative consequences on service users (Foucault, 1980; Mills, 2003; Formosa, 2015). The misuse of power can be the origin of poor care and negatively influence care delivery in this context. Service users are in favour of de-escalation, claiming this choice is preferred when there is a heightening of challenging behaviour (Price *et al.*, 2018b). It was found that a few participants in this study, despite an awareness of the principles of PBS, had developed a

tendency to use it from a perspective of being 'in control' instead of empowering service users to take control of their own care (see RMN 3, 5.3.4).

Foucault's theories on power and knowledge are well discussed in psychiatry and mental health nursing (Roberts, 2005; Price *et al.*, 2018a), and the Foucauldian approach is a much-debated topic in mental health settings (Stevenson and Cutcliffe, 2006). The theory seems to depict power and knowledge as having a strong potential influence on nurses and the care they provide in mental health environments. As Bradbury-Jones *et al*. (2007) have suggested, people who are in powerful situations may have the ability and agility to apply the interpretation of their truth (i.e. what *they* believe in). One's belief could be detrimental if the PBS model were perceived as a non-contextual fit. The use of control, restraint, seclusion and PRN medications are all examples of how power can be exercised on others, often without the full appreciation of the impact of such practices on the well-being of oneself and others (Hext *et al*., 2018). A sound level of awareness of these aspects is fundamental for influencing changes in mental health; however, the shortcoming of Foucauldian analysis is that it may portray mental health professionals, including myself, as those who utilise their power to keep service users within restrictive environments, and manifest a need to be in control. Many participants in my study have alluded to the fact that, although the fidelity of the nurses to PBS was questioned, any deviation from proposed plans including PBS might be due to ward rules, staff shortage, service users being detained under mental health sections, lack of engagement from different stakeholders, or PBS being a labour intense process (Hennessy, 2017). Additional factors that could influence PBS, include service users' presentation, their involvement with the process, and their capacity to engage with the intervention.

The DH (2014) has raised several concerns after the death of service users who have been subjected to these practices in mental health or learning disabilities services (Taylor *et al.*, 2017). My literature review (see 3.6.1) identified PBS as an effective framework in diverse areas including school, healthcare services and juvenile environments. The findings from my study established a link between PBS and restrictive interventions whereby the framework plays an integral part in enhancing individuals' quality of life, as described by RNLD 6 in section 5.3.4.1.

However, restrictive interventions may occasionally be necessary to safeguard the best interests of individuals involved (Hui, 2017; Power *et al.*, 2020). Examples of worldwide practices considered restrictive consist of deprivation of liberty, forceful administration of medications, hospital detention against someone's will, physical restraint, seclusion, and the

use of force (Kallert *et al.*, 2011). However, in the UK, the CQC (2007, 2019) has guided health organisations (mental health, learning disabilities and autism services) relating to measures and strategies to be in place to reduce the use of the restrictive intervention. There is also an expectation that service users are supported with appropriate PBS plans that endorse the least restrictive interventions (Whyte, 2016; CQC, 2017; Clark *et al.*, 2017). Besides this, the findings of my study suggest that care staff require a good understanding of challenging behaviour. A sound understanding of challenging behaviour, acquired through appropriate training, equips staff with the necessary expertise to deal with behaviours of concern, thereby becoming less dependent on restrictive interventions (Reeves, 2017); its realisation is reliant on specific education and acquisition of competence. A lack of exposure to challenging behaviour training may leave nurses and other colleagues ill-prepared to cope in demanding situations (Hext *et al.*, 2018). It is further emphasised by the participants that proper recognition of service users' human rights is crucially important in the care delivery process, and is a fundamental feature of PBS, as supported by Gore and Umizawa, (2011).

'Human rights' features as a sub-theme under 'restrictive interventions'. The tenets of human rights (Human Rights Act, 1998 – Section 3) revolve around treating individuals with respect and compassion while offering choices and support. Many participants in my study were aware that the treatment of individuals through the application of restrictive practices as a punitive measure breaches these values. Human rights and their link with mental health have long been associated with dominance, power, control and restrictions (Cleary, 2003; Mead and Filson, 2017). RMN 9 (see 5.3.4.2) expressed their views regarding patients' human rights and the role that PBS plays in safeguarding dignity and maintaining respect, albeit in challenging situations.

Evidence indicates that service users are in favour of de-escalation, claiming this choice is preferred when there is an escalation of behaviour (Price *et al.*, 2018b). It was found that participants in this study had due regard to patients' rights and the significance of providing respectful treatment while making the necessary adjustments to meet the needs of the patients. My study has highlighted nurses' commitment to maintaining patients' dignity by providing care in a respectful manner.

It is documented that individuals who have complex needs should be supported to develop coping mechanisms in an environment that is least restrictive (Hui, 2017). Equally, when staff are skilled at building and maintaining therapeutic relationships with service users there are long-term positive outcomes (Pazargadi *et al.*, 2015). Similarly, the ethical, legal, and moral obligations bind us to deliver care in a way that respects the recipient's dignity

(Gabrielsson *et al.,* 2016). While these qualities are beneficial, I have established, through additional research, a lack of literature addressing the ethical challenges that professionals – including nurses – face in their day to day jobs (Hem *et al.,* 2018). My findings refer to some ethical challenges that nurses face. This is illustrated by RNLD 6 who explored practices during which service users were placed in seclusion and long-term segregation following incidents of challenging behaviour. However, in cases where PBS is successfully implemented, service users have been supported during difficult times without having recourse to seclusion or other restrictive interventions. This endorses PBS as a framework with the capacity to prevent situations from escalating. RNLD 6 (see 5.3.4.1) views PBS as a framework that helps address challenging behaviour, and thus potentially reduces restrictive interventions. This view is in line with current evidence (DH, 2014; RCN, 2017b; Hext *et al.,* 2018).

This assessment provides the background for, and understanding of, different behaviours at an early stage of a service user's care pathway – a useful juncture that guides the formation of support plans without resorting to restrictive interventions such as medications, physical restraint, or seclusion (Whyte, 2016; Hext *et al.,* 2018). By intervening in this manner, health professionals are likely to build a more productive rapport with service users and come to be regarded as trustworthy care staff (Gabrielsson *et al.,* 2016). In extreme cases where service users may be acutely unwell, staff may find it difficult to develop rapport with them; this has been of particular concern during the Covid-19 pandemic (Kahl and Correll, 2020). However, service users do recover from acute phases, and when a good relationship is developed it is observed to be extremely therapeutic (Cleary, 2003). In complex situations, de-escalation techniques are often successful when staff have built a rapport with the service user (Price and Baker, 2012; Price *et al.,* 2017). However, although PBS plans consist of de-escalation strategies, its focus is on prevention, giving choices, respect, and understanding the functions of behaviours (PBS Coalition, 2015). Therefore, service user engagement in meaningful activities and the development of strategies in their support are core features of PBS. The role of OTs in assessing and engaging service users is also crucial in that respect (Webber *et al.,* 2017).

Participant RMN 9 (see 5.3.4.1) urged scrutiny of whether the PBS model was being embraced by nursing staff in mental health services. One reason for the slow progression of PBS in mental health settings could be a lack of awareness or the perception that PBS is only effective in learning disability services. In spite of this slow advance into mental health settings, PBS is not fully embedded in certain areas due to specific barriers that my study has

revealed (see 5.3.3.2). More work is required in clinical areas for PBS to be fully implemented. RNLD 6 (see 5.3.6.2) described practices such as behavioural charts about PBS in some services as a behaviour modification strategy.

It is common for professionals in learning disability services to find behaviour modification strategies useful in the management of challenging situations (Martin and Pear, 2015). Similarly, Antecedent Behaviour Consequence (ABC) charts have been used for many years and are viewed as an effective method of dealing with inappropriate behaviours that challenge, particularly in learning disability services (Paley-Wakefield, 2011; Clark *et al.*, 2020). As stated by RMN 3, PBS is sometimes being linked with a reward chart which may help with the behaviour modification strategy but may not help to understand the functions of the behaviour. PBS may therefore be misinterpreted as a behaviour modification framework rather than a framework that improves the quality of life. The findings from my study identified a gap in the way that PBS is being used in some areas.

A pharmacological viewpoint often identifies the overuse of psychotropic medications. Administration of certain medicines may be regarded as restrictive intervention, especially those that have debilitating effects on service users (Bowring *et al.*, 2017; Tsiouris, 2010; Murray *et al.*, 2014). Considering the misuse and low benefits of these medications, PBS is found to be an alternative and credible long-term evidence-based practice for use in a challenging context, as supported by the literature (Lee *et al.*, 2019). My study has found that nurses acknowledge the role of medications in the care of service users, and they argue for a more proactive approach to replace it when possible, as supported by PBS.

PBS could play a crucial part in improving the ward environment. Physical restraint is a contributing factor to nurses' low morale and thus creates a strained environment (Kontio *et al.*, 2012) in an already stressful and anxiety-provoking situation (Strout, 2010; Triggle, 2018). Physical restraint is also a reason for a sentiment of dissatisfaction that mental health nurses feel in their roles (Wilson *et al.*, 2017). The findings of my study have shown nurses' experiences were primarily focused on their patients. This became apparent where the participants felt PBS could address the issue of physical restraint and provide better support for individuals with behaviours that challenge (RNLD 7, 5.3.4).

Indeed, the World Health Organisation (WHO) has established that physical restraint, and other issues such as violence and aggression, contribute to the challenges of recruiting and retaining nurses in healthcare (WHO, 2014). It is therefore timely that seismic measures are taken to change ward environments if nurses' job satisfaction is to improve. In this study nurses, such as RNLD 11 (see 5.3.4.1), value the importance and effectiveness of PBS.

The PBS framework was found to facilitate a therapeutic environment that is recovery-oriented, which does not apply when physical restraint is employed as a primary intervention. However, several additional factors could potentially improve nurses' job satisfaction in challenging situations. Some relate to improved communication, therapeutic relationships between staff and service users, improving the ward environment, and provision of meaningful ward-based activities for service users (Sweeney *et al.*, 2018). Evidence suggests PBS promotes rehabilitation, reduces uses of physical restraint, and addresses the overreliance on medications (Haw and Wolstencroft, 2014; CQC, 2018). This situation may improve the well-being of staff as they undertake their caring role. The flexible and adaptable approach of the PBS framework means that other interventions could well be productively used alongside it to achieve a common goal. RMN 1 talked about this issue in section 5.3.6.1.

My participants accepted that other interventions and frameworks needed considering alongside PBS. RMN 1 accepted that PBS is not the only framework that is useful in areas of challenging behaviour. This statement is supported by the literature, where the safewards model is recognised as an evidence-based intervention that could be implemented in conjunction with PBS to improve service users' experience (Clark *et al.*, 2017). Goulet *et al.* (2017) reviewed least restrictive interventions and found Safewards to be a model that provides flexibility and adaptability.

6.6 Communication

'Communication' was among the six themes that emerged from this study, together with sub-themes of 'leadership' and 'MDT approach' (see 5.3.5). As mentioned, several studies support PBS as an effective method in areas of challenging behaviour (Griffiths and Wilcox, 2013; Davies *et al.*, 2016). However, the argument developed from the findings of my study is that, despite strong evidence for PBS, several factors that may influence its future practice in mental health services. One such factor that emerged from my study is that of effective communication, which is facilitated by strong leadership and meaningful exchanges within an MDT.

PBS is a multi-component model, which means there are associated benefits if an MDT approach is achieved (Karger *et al.*, 2018). However, some tensions are seen to arise when appraising collaborative working in mental health services (Valentine *et al.*, 2015) due to the existence of different frameworks and ideologies in this much-disputed field in our health care system (Herron and Mortimer, 1999; Howard *et al.*, 2018). Nurses and psychiatrists have often favoured the medical approach to care, while clinical psychologists have,

understandably, favoured the psychological model and, similarly, social workers have observed the social model of care (Kirk, 2005; Howard *et al.,* 2018). With such a continuum of perspectives within a single field, everyday challenges orbit around poor inter-professional communication (Bradshaw, 2001; Acharya *et al.,* 2017). Teamworking within an MDT is hindered by obscured roles, difficulties in harmony due to opposing positions, issues around power and control; and all of these are especially prevalent in situations where professionals feel disenfranchised due to a perceived medical dominance or psychological supremacy (Silva *et al.,* 2019), as found in the case of PBS in my study. The perceived tension and conflict may confuse patient treatment and interventions (Karben, 2011; Bailey, 2012). Clearly, such an atmosphere does not benefit PBS, and the integrity of the model may consequently become flawed to such an extent that intervention could become disregarded in a complex mental health service. It is also reported that failure to effectively implement PBS could result from lack of proper care planning and review (Hieneman and Dunlap, 2000; Davies *et al.,* 2016). This study finds organisational leadership crucial for the advancement of PBS, as alluded to by RMN 3 (see 5.3.5) who referred to an absence of that leadership guiding PBS implementation. This appears to be aggravated by a serious communication issue within teams, and further compounded by inconsistency.

RMN 3's views are in line with current literature when suggesting that the success of PBS is dependent on appropriate and effective communication in practice (Webber *et al.,* 2017). This argument is coherent with other studies, where leadership, communication and an MDT approach are all regarded as prerequisites (Woolls *et al.,* 2012; Houchins *et al.,* 2005; Frey *et al.,* 2010; Browne *et al.,* 2014). I, therefore, find a strategic and organisational approach to implementation to be a fundamental aspect that needs to be instigated for the effective integration of PBS in health care services.

Solid leadership and effective communication within teams are vital for the continued positive development of PBS, together with efficient MDT collaboration (Andreou *et al.,* 2015). It was clear from my study findings that nurses, for instance, RNLD 5 (see 5.3.5.2), did not feel fully involved by clinical psychologists, who customarily take a lead in the implementation of PBS.

In Chapter 5, I presented the findings that nurses would favour having an advanced role in designing, implementing, and evaluating PBS, which I feel can be achieved through a departure from medical and psychological dominance, and through adopting a more psycho-socio model where nursing could play an integral part. In that respect, a call for strong leadership and appropriate support both at service and organisational levels are well

documented (Lohrmann *et al.,* 2008; Bambara *et al.,* 2009; Hennessy, 2017; Andreou *et al.,* 2015).

Communication, however, encompasses more than effective interaction between team members; it requires useful and ongoing communication with the service users who are the main stakeholders in the whole PBS process. This is explained by RNLD 15 (see 5.3.5), RMN 4 (see 5.3.5.2) and RNLD 10 (see 5.3.5.2).

The communication part of an engagement process could become complicated, as working and building therapeutic relationships with people who are perceived as challenging may be problematic (Kahl and Correll, 2020). Notwithstanding, it is vital for professionals, including nurses, to work closely with service users, as the focal players and beneficiaries in PBS, to build therapeutic relationships that lead towards the effective application of PBS (Browne *et al.,* 2014). The participants in my study expressed themselves in line with Karger *et al.* (2018) who have identified communication and collaborative working as important considerations, together with the need to build and maintain professional rapport. RMN 9 (see 5.3.5.1), for instance, talks about contribution and input from everybody through clear communication.

Despite some indisputable evidence, more work is necessary to evaluate the benefits of communication, MDT functioning, and leadership in PBS practice. My participants, such as RMN 8 (see 5.3.5.1), referred to communication transcending team level, to include external agencies and stakeholders outside the health organisation. This is in support of the delivery of PBS, sharing good practice, and educating staff on PBS.

A government paper on the need to reduce restrictive interventions (DH, 2014) epitomises the significance of leadership as a core element that drives the reduction of restrictive interventions in mental health. However, I argue that leadership is effective when supported by policies and appropriate systems being in place. Leadership is about the presence of the right individuals or team who are able to drive forward a common cause, such as enhancing the quality of life, which is supported by corporate accountability and governance structures. This is not to undermine the importance of a co-produced approach (Rose and Kalathil, 2019). The DH (2014, p. 32) strongly advocates for leadership in practice that supports both service users and staff:

> *'Provide adequate information, instruction, training and supervision to ensure the health and safety of the employees.'*

There is strong emphasis on a strategic approach including training and supervision that ensures the safety of all stakeholders.

However, Professor West from the King's Fund (2014), argues for a collective leadership model where everybody takes responsibility in ensuring positive outcomes within the organisation; one that also nurtures development of a compassionate culture in the NHS (West *et al.,* 2014). The Center for Creative Leadership published the 'Developing Collective Leadership for Health Care' paper, supporting structured approaches to leadership that promote collective decision-making in a climate of equal influence (West *et al.,* 2014). The argument posits traditional leadership models as anachronistic and not fit for purpose. An inclusive and innovative leadership structure is directly linked to successfully performing NHS organisations (Carragher and Gormley, 2017). An organisational structure of collective leadership comprises engagement from all stakeholders from different levels and includes student nurses to senior nurses as policymakers (Hartley and Benington, 2011; DH, 2012b). This argument could benefit the advancement of PBS in practice through leadership and working collaboratively.

In my study, leadership in practice was considered an indispensable element of PBS and complements existing evidence (Beadle-Brown *et al.,* 2012; PBS Coalition, 2015; Webber *et al.,* 2017). Leadership emanating from experienced managers and clinicians working in direct contact with service users is deemed decisive in upholding PBS standards and achieving positive outcomes. In this context, leadership could refer to the support that staff receive during PBS implementation: coaching and modelling, one-to-one supervision support, and team meetings where the framework is discussed within the team (RNLD 12, 5.3.5.1 and RMN 1, 5.3.5.2).

Additionally, practice leadership is aimed at helping embed PBS bringing about positive change at assorted levels. While leadership is described as indubitably essential, it is not clear what preparation or training these leaders and managers need to successfully assume proficient leadership roles (Deveau, 2015), although it is argued that practice leaders require the experience and competencies to deliver the expected aims and objectives of PBS. Sullivan and Garland (2010) describe leadership as the use of different skills to guide and inspire others in the accomplishment of stated objectives. Therefore, my study identifies the presence of strong leadership as being a fundamental requirement necessary to drive the PBS framework; but there was an additional need to bring people together when enacting PBS, as mentioned by RMN 4 (see 5.3.5.1).

Cockerton *et al.* (2015) have argued the usefulness of the Safewards model in reducing restrictive interventions at a London NHS trust, where the model was facilitated by a team of practice development nurses. While this approach has produced some good results in that organisation, risks around sustainability are present because the absence of a dedicated senior person, at a leadership level and accountable to the trust board, may affect future delivery of the initiative. This concern is equally valid in respect of PBS where the presence and contribution of senior nurses with the required commitment is significant for any evidence base intervention to become successful (Savarimuthu, 2020). In the current health and social care climate, where the tension between financial and professional priorities is palpable (Foss *et al.*, 2014; Ham, 2018), leaders often miss the most important elements of effective leadership, comprising staff engagement, physical/visible presence and the development of the workforce (Hayward *et al.*, 2021). However, the significance of experts by experience and service users' input in the decision-making processes is well documented (Barrett *et al.*, 2014; Waegeli, 2014; Perkins *et al.*, 2015).

6.7 Effectiveness of PBS

The findings from my research compound existing evidence depicting PBS as a philosophy that is useful and effective in areas of challenging behaviour. Although PBS is a relatively new construct, my study found nurses were eager to develop their understanding of the model and they wanted to learn how to confidently apply PBS with positive effects as illustrated by RMN 12 (see 5.3.6.3).

My literature review (see 3.6.1) identified PBS as an effective framework that helps reduce challenging behaviour in both mental health and learning disability services. Although participants from my study have used PBS in a way that may seem paternalistic, most nurses have described PBS as a framework that is effective in behaviours that challenge as described by RNLD 18 and RNLD 19:

> *'I think it's a really kind of useful and can be effective if it's done in the right way – that people understand it to kind of reducing behaviours of concerns.'* (RNLD 18)

> *'From my experience I find PBS as a good tool to support people with challenging behaviour including children.'* (RNLD 19)

Wide-ranging evidence exists on the effectiveness of PBS, extending from special school settings to clinical practices (Anderson-Ketchmark and Alvarez, 2010). It is argued that PBS provides a long-lasting effect in situations where inappropriate, unacceptable, or challenging behaviours occur. PBS supports individuals who are susceptible to developing complex needs in the future (PBS Coalition, 2015). Therefore, it is proposed that in extreme cases PBS could form part of a package of interventions that incorporate pharmacological input.

On a continuum, service users may lack mental capacity; some may be detained under different sections of the Mental Health Act (1983), and others may be too unwell to engage in their own care. This population group may require specific measures are in place to enhance their patient involvement in PBS. Input from other stakeholders may comprise support from speech and language therapists, independent mental capacity advocates and family carers. This level of engagement and interaction ensures the co-production of PBS (Jones, 2014; Webber *et al.,* 2017). My study brings some insight regarding the effectiveness of PBS through a person-centred co-produced approach as highlighted by RNLD 11:

> *'And I think this approach is very useful as it put things into perspective- you actually see it happening and this is supported by the discussion- and people's experience with patient.'* (RNLD 11)

However, co-production of PBS may mean a more complex process in situations involving acutely unwell service users and those who lack mental capacity. Therefore, although its effectiveness is well documented, in complex scenarios, PBS requires a careful and structured application while considering individual needs such as the service user's mental illness, a diagnosis of learning disability, or service users' mental capacity and insight.

The theme of 'effectiveness' that emerged from this study is in line with my literature review (see 3.6.1 – 3.6.5) where PBS is identified as a successful framework. However, from that review there is little mention of other useful interventions alongside PBS, such as pharmacology, CBT, or motivational interviewing (Frankish and Terry, 2003; Rana *et al.,* 2013; Turner *et al.,* 2014). These interventions can equally be valuable in supporting people with behaviours of concern. From my literature review, I was not able to find a well-defined and distinct positioning of PBS as a framework to be used with other tools and interventions; but PBS cannot be viewed as the sole and exclusive practice in treating challenging behaviour. For instance, a few participants in my study, such as RNLD 7 and

RMN 1 (see 5.3.6.1), were aware of the importance of other interventions in the management of challenging behaviour.

As part of a care package in a healthcare environment, service users receive a broad range of therapies, such as occupational therapy, psychotherapy, or CBT (Frankish and Terry, 2003). Bearing this in mind, the aim of PBS as highlighted in my study, is to help improve the quality of care but also to acknowledge that the elimination of challenging behaviour may not be possible in every patient. Moreover, any care pathway should encompass a culture of shared decision-making, the co-production of care plans and protection of each service user's rights and choices. Co-production is more than the mere presence of service users at different levels of decision-making; more accurately, it is a situation where there is power redistribution that facilitates a healthy, productive, and cooperative interaction between health professionals and people with lived experience (Rose *et al.*, 2018). The incidents at Winterbourne View in 2011, Mid Staffordshire in 2009, and Whorlton Hall in 2019, have exposed abuse, neglect and poor care that has triggered an intensive drive to espouse measures to improve the care of vulnerable service users. There is indeed a concerted effort to change a culture that accepts and normalises restrictive interventions in health care organisations and arrive at a more supportive approach (Kinner *et al.*, 2017). My study has shed some light on how PBS could be part of that culture change. While there is a willingness to improve practice, I propose that it is essential to find practical ways to move forward in the field of challenging behaviour by further developing PBS.

This study has reinforced existing evidence in establishing a link between PBS and challenging behaviour, where successful use of the framework can help support individuals with behaviours of concern. Nonetheless, it is of parallel importance to analyse and introduce other interventions. For instance, the use of specific medications has seemed beneficial in treating certain mental health conditions that characterise challenging behaviour (Willner, 2015). Psychopharmacological approaches and behavioural interventions are often associated with the care of challenging behaviour, although there is no substantial evidence exploring the interaction of psychopharmacology and challenging behaviour (Cox and Virués-Ortega, 2016).

An important feature of PBS is its ability to educate service users towards developing coping mechanisms without having recourse to challenging behaviour (Gore *et al.*, 2015). The process of engaging service users often encounters challenges, particularly when individuals are acutely unwell or have a learning disability, certain conditions, or personality traits that may compromise their capability to develop skills (DHSC, 2019b).

Few participants, including RMN 3 (see 5.3.6.2), felt that PBS was regularly being used as a positive reinforcement where service users were rewarded for good behaviour. The comments from RMN 3 suggests a gap in awareness and that more work is required to further develop competence, knowledge, and skills around PBS. Behaviour modification strategy, while commonly used in mental health and learning disability services (Martin and Pear, 2015), is not an exclusive feature of PBS. PBS goes beyond the reinforcement or encouragement of good behaviours; it is a framework that encompasses many characteristics, one being the provision of educational support for individuals to learn positive and acceptable behaviours instead of exhibiting problematic ones (Gore *et al.,* 2013; Goh and Bambara, 2013). It can be argued that, by portraying PBS in this way, some nurses may have missed opportunities to observe its positive effects such as enhancing the quality of life (see 2.5.2). PBS runs the risk of being used inappropriately with accompanying unrealistic expectations. However, the PBS competency framework (see 2.5.1) provides and acts as a safeguard ensuring the high standard of PBS is maintained (PBS Coalition, 2015). PBS training remains elementary in understanding the framework as a tool that contribute towards providing a socially valid lifestyle for service users (Grey *et al.,* 2016). Some of the desired outcomes of PBS are the development of supportive relationships, holding productive and meaningful employment, engaging in educational prospects, and acquiring skills that may increase independent community living (Grey *et al.*, 2016). Therefore, PBS should not be regarded as a stand-alone intervention, rather be a multi-element support strategy as my study has demonstrated. RNLD 5 (see 5.3.6.2) has seen the effectiveness of PBS in addressing behaviours that challenge.

It became apparent from my findings that PBS is a common practice in learning disability settings compared to mental health wards. This is perhaps because of the perception that PBS more relevantly supports people who have intellectual disabilities (Baker and Allen, 2012). However, while there is growing evidence that the framework works in mental health services too (Griffiths and Wilcox, 2013), nurses need to appreciate that the intended purpose of PBS is to enhance the quality of life while also reducing restrictive interventions (LaVigna and Willis, 2012; Davies *et al.*, 2016). One concern is that poor understanding of the PBS framework may create an expectation that the practice can reduce problematic behaviour in every situation (Hassiotis *et al.*, 2018). However, my papers (Savarimuthu, 2019, 2020) have tried to bridge the gap around PBS at a local level and nationally (Appendix 17). The dissemination of knowledge can help mitigate any sense of failure or rejection when no changes to challenging behaviour are observed, due to weak implementation of PBS

(Hassiotis *et al.,* 2018). This is the case, even though challenging behaviour may not always significantly diminish but, instead, the patient's projected quality of life may improve within a less restrictive environment (Allen *et al.,* 2012). Conversely, while the use of restrictive interventions is not supported by PBS, in some context restrictions may be inevitable (LaVigna and Willis, 2012). Restrictive measures are applied as a last resort only after non-invasive strategies have failed to produce a safe response (LaVigna and Willis, 2012; Jones, 2014). These practices, where applicable, should be employed in a respectful and dignified way while safeguarding the interest of the individuals – and PBS is about ensuring that this is done appropriately (see 2.5.1). This point is put forward by RMN 17.

Nevertheless, PBS remains a successful framework against the backdrop of fewer expected restrictive interventions, most particularly in cases of immediate risks such as self-injurious behaviour, suicide or serious health and life-threatening situations (Kinner *et al.,* 2017).

While there is a desire to include PBS in care delivery, the inclusion of this tool in the nationwide nursing apprenticeship training scheme is ideal for NHS Trusts in the formation of future PBS competent nurses (Glasper, 2014, Baker, 2019), and similarly, health organisations need to work in partnership with stakeholders such as educational institutions in the training of its workforce.

RMN 8 (see 5.3.6.3) flags up a link between PBS being a new framework and the need for training. This association cannot be disputed from the point of view of knowledge and competence. However, training or awareness sessions are not the only solution to help embrace PBS in the workplace. It is important to create a culture at work that not only accepts PBS but any evidence-based interventions. Accountability and duty of care are tenets of a person-centred care philosophy that leaders should encourage in practice (Hayward *et al.,* 2021). Participants frequently referred to other interventions with which they were more familiar, as illustrated by RMN 8 (see 5.3.6.1).

The comparison or alternative to other interventions may be a sign that staff were overwhelmed with the different interventions already available in some clinical areas. This may create a situation where PBS makes slow progress filtering into the system. The result becomes a revolving door where slow progression, or a lack of it, may mean PBS cannot be fully evaluated and hence its benefits are neither assessed nor embraced (Hayward *et al.,* 2021). However, in my organisation where the integration is happening, albeit slowly, staff recognise the framework's advantages or can at least appraise the benefits, such as those

described by RNLD 11 (see 5.3.6.3). RMN 15 (see 5.3.6.3) went further by positing that staff do not see the importance of PBS, particularly when the framework is not being used.

Informal discussion can be a good way of introducing the PBS framework in mental health services. These discussions can happen at different levels and involve local universities so as to bring greater credibility and fresh perspectives to a relatively new framework. Health organisations may also need to work closely with universities in order to introduce PBS as a topic in the pre-registration nursing curriculum. Certainly, this attempt could ensure newly qualified nurses are well versed in PBS at the point they enter employment. Currently, PBS is not taught at the universities that have a close link with my organisation. The development of such training and discussion could equip newly qualified nurses with useful background knowledge. From a wider perspective, the NMC has identified and accepted that there are gaps in knowledge of how the current nursing curriculum is set (NMC, 2018); a curriculum review would therefore be needed for PBS to be incorporated as part of compulsory taught elements at universities (Dean, 2017). To achieve this aim, lecturers and the teaching personnel would require some exposure and awareness of PBS.

The general findings from my study have shown nurses' acceptance of PBS as an effective model. However, for many nurses, PBS remains a new model and challenges are associated with its implementation (Clark *et al.*, 2020). This assertion adds to existing evidence that positions the PBS model favourably in health care (CQC, 2017). However, it would be desirable to see PBS in action in contrasting areas of mental health services (i.e. acute and community services) as it is already being used within the forensic services (Griffiths and Wilcox, 2013).

6.8 Conclusion, contribution to knowledge and originality

This chapter has provided an in-depth discussion of the findings of this study underpinned by Chapters 3, 4 and 5, together with the emergent six themes, which are training, resources, psychology-led practice, communication, restrictive interventions, and the effectiveness of a new construct. The discussion considered the participants' experience of PBS in its current context and in relation to existing literature. This was demonstrated through advocating for improving care by using the PBS framework, which includes MDT members, and evidence as to where the findings of my study may contribute to ameliorated services.

My research, and therefore contribution to knowledge, has highlighted ways to bridge the gap identified in current PBS literature. I located a gap in the existing evidence base

regarding nurses' PBS experience as an independent group. In section 3.6.1, in a systematic literature review, I have presented the existing literature, reviewed the evidence on PBS, and highlighted the gap regarding nurses' experience of the framework. I therefore submit this as a relevant and viable contribution to the field of PBS and its future practice.

An essential contribution from my study regards PBS training. My research has reinforced the importance of structured, systematic, and practical PBS training for nurses and other stakeholders so that service users are provided with the most up to date evidence-based intervention. PBS training was found to be worthwhile purpose in empowering nurses in order to address the knowledge gap that currently exists between clinical psychologists and nurses. A redress of this imbalance may re-align nurses' position in the field of PBS. While training is a theme previously identified from my literature review (see 3.6.2), the contribution offered by my study brings is located in the disparity of knowledge and control between nurses and other MDT members'.

As my study has revealed, there is a perception that PBS is psychology-led, a situation that posits nurses observe a dominance from psychologists in leading and facilitating the framework. Based securely on current evidence and my literature review, this contribution to knowledge is distinctive in the field of PBS and illuminates the framework from a unique angle. In addition, my study has identified and launched a discourse around the lack of involvement from nurses, who are often found in a secondary position. Nurses advocate for additional training and show willingness to take up leadership roles within the design and implementation of the PBS framework. Current literature has not identified this as a barrier to PBS advancement. Nurses identify that resources such as skilled workers, leadership, communication, and an MDT approach are essential factors that influence PBS implementation. I also present a contextual discussion around staff shortages affecting the practical facilitation of PBS.

Thus, another original contribution that my study brings to the PBS knowledge base addresses the significance of resources in its effective delivery. I have contextualised resources within the terms of staffing, leadership, and teamwork. No previous research has shed light on these central aspects of PBS delivery and patient care. My findings heavily re-emphasise teamworking as being an essential element for successful PBS, even though the benefits of teamworking are well documented in healthcare generally. Against a backdrop of perceived conflict between members of the MDT, this knowledge as identified helps address issues of potentially influential professional attitudes and culture. My study proposes issues

of hierarchy, status, and professional disregard, as barriers to the development and extended application of PBS.

My study is the first, that I am aware of, that explores the PBS nursing experience of nurses and its relationship to restrictive interventions. The research is also distinctive from a methodological viewpoint in which hermeneutic phenomenology captures the lived experiences of participants. Respect for service users' and their rights were strongly advocated, which reinforces the principles of PBS (NICE, 2018). Another contribution made confirms the effectiveness of PBS, already documented in literature (see 3.6) and evidence gathered from contextual reading. However, my study's most unique contribution is discussion of useful interventions that are complementary to PBS. My own experience of PBS is that it can be efficiently used alongside many other interventions, tools, and therapies. This element surfaced strongly in this study, bringing with it a fresh dimension and extra level of understanding of how PBS can be flexible and adaptable to working in conjunction with a wide range of practices, such as CBT, occupational therapy, and psychotherapy.

7.0 Conclusion and Recommendations

7.1 Introduction to chapter

This concluding chapter presents the strength and limitations of this research and is followed by a series of recommendations that emanate from the study. This section also demonstrates the approach taken to disseminate my research findings, and explores a number of implications for practice, future research, and education and training.

7.2 Strength and limitations

7.2.1 Strength

My research and thesis have provided an in-depth exploration of nurses' viewpoints of PBS in a mental health organisation, and thereby contributed to the existing body of evidence and literature in this field of PBS. Further, my study has offered a distinctive methodological contribution in which hermeneutic phenomenology was employed during interpretation of the lived experiences of a group of nurses. My literature review did not uncover PBS research using this methodology, so making it unique in the field of PBS.

Indeed, my literature review (see 3.8) depicted a gap in the evidence base concerning nurses' experience of PBS, which further endorses its original contribution to the existing evidence base. My findings are categorised under the six themes that emerged and were explored in Chapter 5 (see 5.2.6), and an in-depth discussion of the themes follows in Chapter 6 (see 6.2). Consequently, a pertinent and major contribution of this study is the knowledge it generates from the unique perspective of RMNs at work that addresses a current knowledge gap. My research is the first (to my knowledge) to specifically and exclusively analyse the experience of nineteen nurses who have a valuable and prominent role in a mental health organisation that implements PBS. The findings highlight a perception of potential conflict between nurses and clinical psychologists. This aspect is explored in section 5.3.3. Therefore, my study contributes towards initiating relevant debates and discussions in the hope of better understanding this conflict, resolving it, and heading towards a positive impact on care delivery, where nurses play a prominent role in the implementation of PBS. My research has identified issues of an MDT hierarchy (within a PBS context), which nurses perceive to be dominated by clinical psychologists despite a call for collective leadership in healthcare. This perception offers a fresh level of understanding to issues of status and hierarchy in healthcare.

By using hermeneutic phenomenology, during data analysis, I could draw on my experience of PBS as an NHS nurse consultant. My position in the world of PBS, and my

insights into the intervention, were useful during data analysis, meaning I could offer an informed interpretation of my participants' lived experience. My background with PBS supported my understanding of the participants' experiences. Subjectivity and reflexivity were significant factors influencing my role as a researcher. Had I lacked a PBS background I would doubtless have interpreted the data differently. Even sharing background elements with my participants, I may at times have held different views, but through reflexivity (see 4.4) I feel my knowledge and personal experience allowed for systematic and informed interpretation of the nurse's narratives. My chosen methodology facilitated an in-depth exploration of the participants' lived experience and contributed a strength that is grounded in the rich data afforded by one-to-one interview, where the data must remain uncontaminated by other participants as it would be in a focus group (Webb and Kevern, 2001; see 4.3).

7.2.2 Limitations

There were several limitations to this study. It was positioned within the qualitative paradigm which relies on the participants to be open and honest about their experiences. However, I strongly believed that interviews were the most appropriate method for data collection. This was due to the fact that the subject matter was a sensitive issue, and I was aiming for the emergence of 'in-depth' data to enhance the knowledge base about PBS. I did consider the use of focus groups (within the qualitative paradigm) but decided that participants within this scenario would be expected to share their professional experiences (discuss, explore, and reflect) about their PBS experiences within a somewhat public forum (Webb and Kevern, 2001). As mentioned above, the data could have been deemed 'contaminated'. In addition, I do acknowledge that a mixed methods approach, from the quantitative paradigm (using generic, non-personal questionnaires) initially, may have revealed the extent and level of knowledge and experiences about PBS from the participants. This, in turn, could have informed the design of the semi-structured interview schedule.

Although I have been self-reflective and aware of my own PBS biases, I am mindful that remnants of bias may nonetheless influence the study, especially during the interpretation stage, as bracketing is not a feature of hermeneutic phenomenology. However, in section 4.4, I have described the reflexive approach I took to safeguard a robust and trustworthy study process. Besides, in this study there was no service user researcher involved, and this could be another limitation as service users' interpretation could have been useful in understanding PBS experience.

Regarding sample size, as discussed in section 4.6, it is not possible to determine this from the onset in qualitative studies. Saturation in qualitative research, and especially in phenomenology, is a much-discussed concept (van Manen *et al.* 2016; Vasileiou *et al.*, 2018). Potentially a sample larger than nineteen participants may have produced additional data.

While strongly believing that one to one interview was the most appropriate method for data collection, considering the sensitiveness of the subject and aiming for the emergence of in-depth data, I am equally mindful that focus groups may have helped participants to discuss, explore and reflect on their PBS experiences (Webb and Kevern, 2001).

The Covid-19 pandemic has had a negative impact on research in general, including mine (Byrom, 2020). Due to implications of the pandemic and social distancing rules, most participants (n=10) were interviewed online, and three participants (n=3) wore face masks during face-to-face interviews where masks may have hindered the communication process, as facial expression was hidden (Mheidly *et al.*, 2020). Though I did not record observations during the interviews, it may have presented a challenge for the participants to fully establish or build rapport with me when wearing face masks and maintaining a greater than usual physical distance. During the Covid-19 pandemic, staff have undergone additional stress from work pressures (Singh, 2021), and I acknowledge that this may or may not have impacted on their responses and experience of PBS. Although I did everything possible at the time of interviews to help participants feel comfortable, the effect of Covid-19 coupled with new work demands upon morale remain unknown, hence this may have influenced the nurses' experiences (Singh, 2021).

Online MS team interviews have allowed more nurses to participate in my study, although this communication method has inbuilt challenges for engaging in a conversation that may make it feel more like a question and answer session (Newman *et al.*, 2021). Because of this, participants completing a questionnaire in their own time and place, then followed up by an interview may have consolidated the PBS data or yielded further data.

Each interview lasted an hour, maximum. This time allocation may not have been sufficient for participants to build rapport with me, thus potentially impacting the depth of the conversation. None stated this to be the case, but the possibility remains. The offer of individual follow-up interviews may have facilitated them sharing further experience if they remembered it at a later stage. Alternatively, I could have shared the transcripts with the participants for them to add further comments.

Another limitation of this study is that participants were recruited from a single NHS organisation, meaning it was not a representative group of registered nurses across the board, so caution is required in generalising these findings to other services. A sample of participants from an organisation located in an inner-city area of London may have yielded contrasting findings dependent upon the type of services and the population group they serve. I remain mindful that, although I did everything to make the participants comfortable to speak honestly, the possible effect of being interviewed by a senior trust member may have influenced them to say the 'right thing'. This scenario may have influenced their interview responses.

7.3 Recommendations for practice improvement

Restrictive interventions emerge as a strong theme from my study. My participants spoke about the important role that service users can play in reducing restrictive interventions in their own care. However, participants experience reflected that co-production was not practiced consistently within the organisation. To enhance co-production and service user engagement in PBS, I suggest the adoption and implementation, in my organisation, of a consumer leadership model that works to achieve a committed and consistent approach.

Attainment of an operational consumer leadership model in my trust will require a wide range of essential groundwork that addresses power sharing, empowerment, and the generation of knowledge (Faulkner *et al.*, 2021). Since it is documented that service users and survivors frequently come from a disadvantaged background where they may have been marginalised, any empowerment process needs be carefully and systematically approached (Rogers and Pilgrim, 2021). For instance, my mental health organisation, while committed to engaging service users, will need to clarify service users' roles within the MDT hierarchy. During that process it will be imperative to acknowledge service users' skills, experience, and competence in order to establish a rigorous strength-based approach. Advocacy services may be required and should be provided in a sensitive and supportive manner that encourages personal development and widespread service user engagement. I have referred to an Australian model, concerning the creation of relevant networks and groups that provide direction, support, and expectations around service user engagement and consumer leadership (Scholz *et al.*, 2017). Nevertheless, in the current context of Covid-19 a new approach to networking could include the use of social media and digital platforms but with the necessary level of monitoring and governance to protect vulnerable individuals. A north-central London mental health consumers' platform, or group, for those interested in becoming service

leaders, may be something that my health service could initiate in attempting to create opportunities for new roles and provide a supportive infrastructure. For consumer leadership to be embedded in the fabric and culture of my organisation a policy shift may be needed. This is supported by Russo *et al.* (2018), who argue that corporate validation is a useful assurance regarding the effectiveness and implementation of consumer leadership. Considering this, nurses and other professional leaders would play an important role in facilitating a power-sharing process that allows service users into the organisational hierarchies, and thus ensure power does not remain concentrated at the top (Jones and Shattell, 2016; Segal and Hayes, 2016).

With regard to working in partnership, the study findings have shown a disjointed approach from MDT in relation to PBS. To enhance the effectiveness of PBS, support individuals with behaviours that challenge and reduce restrictive interventions, one suggestion is to create a local/regional initiative such as a pan-London confederation to develop, co-ordinate and implement relevant strategies. This idea stems from my study findings through which I have become more conscious of the importance and expert input of other disciplines and agencies in the delivery of PBS. The concept being proposed is similar to the 'London Pathways Partnership' that consists of various London NHS trusts sharing a platform and offering advice, guidance and specialist services to individuals with personality disorders (Craissati, 2017). Currently, my trust has introduced a partnership working arrangement with another local NHS mental health trust; this collaborative work, called the 'Keeping us Safe Symposium', aims at sharing good practices, expertise and data relevant to safe working (patient and staff safety), reducing restrictive interventions and addressing behaviours that challenge. This is not unlike the PBS forum that I attended with the North London consortium (see 7.6), which has led to greater network to promote PBS work and share ideas for advancing the framework. Such a concerted effort and an embodied scheme would allow NHS organisations to work together, provided there is the necessary commitment from stakeholders. In the current climate of financial challenges for mental health services, it could be a struggle to keep any collaborative model alive, productive, and sustainable in the long run (Cummins, 2018). For this reason, it may be opportune for new initiatives to explore those current challenges of fiscal constraint, lack of resources, staff shortage and burnout. A digital and e-platform could be a valid alternative to interface interactions, especially when staff cannot be released to attend these collaborative works and considering the current covid-19 pandemic where online and digital working has proved beneficial (Torous *et al.*, 2020).

The study participants have found PBS effective in improving patients' quality of life while reducing restrictive interventions. I therefore recommend a trust-wide implementation of the framework. This process should involve and support nurses in adopting PBS as an evidence-based practice in an organisational agenda to reduce restrictive interventions. Service users and nurses were established in my findings to have a well-established therapeutic relationship, indicating that nurses are advantaged as a group compared to other members of the MDT such as doctors, clinical psychologists or OTs. The relationship between nurses and services users is central to positive implementation of PBS. The outcomes of this study, together with my input, have influenced the introduction of PBS in the trust's Quality Improvement (QI) strategy to reduce restrictive interventions, albeit not in all areas of the organisation. To facilitate a consistent and sustainable approach to PBS, I recommend that nurses' preceptorship programme should include PBS as a core element so that every nurse develops some competencies in using the framework. The programme, as recommended by the NMC, is designed to support newly qualified nurses through their transition and beyond (NMC, 2008). The NHS Long Term Plan published in 2019 sets out clear objectives towards digitalisation of the NHS and emphasises the function of technology in care services. Therefore, based on this ambition, I recommend a PBS passport for every service user who can be accessed through an app. Appendix 15 illustrates a PBS passport that I co-designed with a service user who has used the framework as part of his treatment plan.

7.3.1 Recommendations for health services

Participants in my study found PBS a novel framework that is often misunderstood. From my viewpoint, there is a need to learn, share and embed good PBS practice. Based on these observations, I recommend the formation of a PBS digital platform, as it may be a useful initiative that allows individuals to connect with different local organisations. This movement could fulfil learning needs and engage stakeholders in the development, practice, and evaluation of PBS. Membership to this platform may comprise experts by experience, clinicians, carers, and PBS practitioners. A PBS network that connects local organisations, academics, researchers, and service users could enhance PBS awareness, improve care, and contribute towards the support of individuals with behaviours that challenge. The network may also offer opportunities to benchmark with other local organisations utilising PBS.

We are currently in national crisis about the recruitment and retention of nurses (see 4.6.2). It is therefore unsurprising that 'resources' emerged from my study as a theme described to impact the delivery of PBS (Table 8). In the existing situation it is appropriate to

establish structured, innovative, and consistent methods that would help recruit and retain registered nurses, especially in the fields of mental health and learning disabilities (Montgomery *et al.*, 2019). Literature has already established a correlation between preceptorship and recruitment, and there is a plea for preceptorship to be considered an organisational rather than an individual matter (Jonsson *et al.*, 2021). In this context, a high-quality preceptorship programme should focus on staff development, evidence-based practice, and training that improves nurses' confidence and competence to work in challenging environments. However, a preceptorship programme needs to be innovative and fit for purpose, meeting contemporary demands (Baldwin *et al.*, 2020). This programme should receive organisational engagement, including topics such as PBS and awareness of restrictive interventions, and practices that prepare staff for challenging environments. Nevertheless, in its present form, there is currently limited evidence on the impact of preceptorship, on staff confidence (Irwin *et al.*, 2018). It is further recommended that organisations embrace preceptorship as a supportive and mandatory event for all newly qualified nurses, which could potentially enhance recruitment and retention, and address issues of staff burnout and compassion fatigue (Jonsson *et al.*, 2021). For experienced nurses, professional and personal development opportunities within a robust appraisal structure would be helpful (NHS England, 2017).

7.3.2 Recommendations for frontline clinical practice

Communication features as one of my study's findings, as well as some barriers associated with it (see 5.3.5). The participants are of the view that improved communication amongst professional could enhance the effectiveness of PBS. I therefore recommend that, in situations of behaviours that challenge, PBS is embedded in individual care planning and risk assessment that is designed and implemented in a co-productive manner. Additionally, person-centred risk assessment and positive behaviour support plans need to be integral to care planning structures. This could, optimistically, position service users at the forefront of care delivery where they have the chance to take ownership of their care and treatment. However, practice leaders have a central role to play during the implementation of such a model. Nurses as practice leaders could become key players in the accomplishment of such a construct; they can co-ordinate and support PBS delivery. These nurse leaders may also be involved in delivering essential PBS training to colleagues in the MDT. Within this structure, there is an exigence for nurses to play an active role under the reducing restrictive interventions agenda, in various capacities but certainly from a leadership perspective. A

model that I propose relates to the training of two or three individuals in each practice area, in my organisation, as PBS 'champions'. The idea of champions indicates that these individuals would have competencies, skills, and knowledge as prerequisites in their roles to actively support teams, individual staff, and service users in clinical settings.

7.4 Recommendations for further research

My research has identified an MDT approach as fundamental in the effective delivery of PBS (see 5.3.5). Therefore, I am of the view, based on the findings, that further research is needed to establish the experience of an MDT approach to PBS within my organisation. A study of this nature may help identify issues, experiences, barriers, and themes that have the most effect on implementing PBS from an inter-disciplinary perspective. The information and findings from such an investigation could highlight areas where my organisation can prioritise in its continued endeavour to improve services.

Although my study aimed exclusively to capture nurses' experiences of PBS, the role of clinical psychologists emerged as a significant stakeholder in the findings. Hence, the views and experiences of clinical psychologists, who are perceived as a dominant profession regarding PBS, will be useful to compare with that of nurses. The findings from this study may benefit the field of PBS and offer a wide range of opinions to enhance its advancement. Further, an investigation of clinical psychologists' views of PBS and its implementation may help address some of the issues around conflicts and supply appreciation of their roles within an MDT. Wood *et al.* (2019) have confirmed that clinical psychologists remain a not so well understood profession in multidisciplinary teams.

The study participants spoke of potential barriers to the effective implementation of PBS, one of which is community facilitation. An investigation of PBS in the community services would bring useful insights because most service users are cared for in the community. Community experiences of PBS are worth undertaking in the context of the government's encouragement of community care to ease ongoing pressure on hospital beds (Laker *et al.*, 2020). The findings may proactively reduce service users' re-admission into hospital and reinforce the implementation of PBS for their benefit (Newton-Howes, 2013). Therefore, consideration on larger studies, multisite and various stakeholders' involvement would be useful. For instance, my organisation is in partnership with another NHS foundation trust so an exploration of PBS at both organisations can be considered for the future. This could involve more participants such as occupational therapists, doctors and other than nursing staff.

Nurses additionally expressed a lack of confidence in relation to PBS (see 5.3.1). Having been involved in developing PBS training at pre-registration level with a local university (see 7.5.1), it would be interesting to evaluate the PBS confidence of newly registered nurses. Their confidence to work with the PBS framework could add value to its future practice. In the current Covid-19 pandemic and the challenges on mental health wards (such as lack of staffing, resources, level of incidents) PBS could help provide a supportive environment if applied successfully (Laker *et al.* 2020). The findings of such exploration could act as a foundation on which to develop support mechanisms and structures for nurses, and to improve staff recruitment and retention.

7.5 Recommendations for further education and training

7.5.1 PBS training

The findings of my study have highlighted a paucity of PBS training at nurse pre-registration training. To my knowledge, PBS is not a mandatory university subject in pre-registration (MH and LD) nurse training. It is therefore timely that I recommend my organisation to take a proactive approach and to establish a platform involving various key partners who would develop appropriate PBS training for student nurses who attend placements, and to RMNs and RNLDs in general. My organisation could work with other local NHS trusts, including other agencies such as BILD, the PBS academy and the Tizard Centre[1], in a joint effort to support staff with PBS training. Timely exposure to PBS would provide nurses with opportunities to observe the framework in practice, and to see its effectiveness, while supporting student nurses during their clinical placements. PBS training in this context may also offer newly qualified nurses a safe environment where challenging behaviour is supported through evidence-based PBS practice.

It is noteworthy that some recommendations from my study have already been implemented. One, is the commissioning of PBS training by Middlesex University that started in 2021. This programme was developed jointly between my organisation, involving experts in the field of PBS and university academics, and the resultant training is delivered jointly by clinicians and academics. I have now started work with Kingston University to raise awareness of PBS with final year nursing students. As a direct result of my findings, my trust has now embedded PBS as a ‘change idea’ in their quality improvement programme to reduce restrictive interventions across the organisation.

[1] The Tizard Centre is a leading UK academic centre working with autism, learning disability and community care.

7.5.2 Recommendations for an educational pan-London collaborative approach

My study found that most participants had no exposure to PBS during their pre-registration training, and PBS training is one of the predominant themes that emerged. I strongly believe that student nurses in the fields of mental health and learning disabilities should be given all necessary education and preparation to eventually work as registrants in challenging environments. Working towards this, I recommend a partnership between my organisation and other London partners in the form of a symposium that could become an enterprise whereby these organisations join forces to review and support student nurses to gain clinical access during their pre-registration nursing programmes (including acute services where PBS is practised). This partnership could mean learners are offered a wide range of useful placement opportunities for the development of necessary skills for when they encounter challenging behaviour (Adshead *et al.*, 2015). A London-wide placement arrangement could give students access to experienced practice assessors from different organisations as part of their learning process (Stuhlmiller and Tolchard, 2019). In doing so, the education and preparation of nurses becomes an organisational undertaking.

The Nursing Degree Apprenticeship was introduced in a similar vein, as a new route to nursing registration. Considering its long-term benefits, it is expected that the apprenticeship programme is likely to attract interest as it is a route that focuses on the concept of learning while earning (House of Commons Education Select Committee, 2019). The programme is for future nurse training and could be offered in a format that forecasts and equips the nursing workforce to face current and future challenges. I propose a model that supports apprentices on their journey to become newly qualified nurses, by equipping them with the necessary skills to work in challenging environments. A robust and sustainable nurse education, through an apprenticeship scheme incorporating PBS as described above, could allow future nurses to appreciate challenges from both a mental health and learning disability nursing context (Hemingway, 2016). This unique perspective could provide the best possible care in some of the most complex cases of challenging behaviour. While my trust is in favour of this form of training model, its realisation would need the involvement of different stakeholders, such as local universities and other London NHS trusts, working together to establish, monitor, and evaluate the benefits and challenges of such a model. Within a PBS context, mental health and learning disability nurses are both constantly exposed to the framework when working in a challenging environment. PBS is a fitting paradigm that demonstrates, albeit each field being unique, some similarities between mental health and learning disability nursing,

especially over behaviours that challenge, both fields of practice work within challenging situations in numerous ways. The findings of this study have highlighted both RMNs and RNLDs using PBS in resolving behaviours of concern.

7.6 Dissemination of findings

An essential part of this research was to disseminate the findings so that the knowledge generated is shared in appropriate forums, capturing different audiences that include primarily service users and expert by experience. I aim to make an application to present my findings at the 2022 PBS international conference, which will be held in the UK although the dates are not yet published. I will set up a stakeholder engagement forum within my trust, where the findings of this study can be discussed, shared, and reflected upon. The forum will comprise nurses, clinical psychologists, OTs, doctors, and service users. I will use the findings of this study to develop appropriate policies, especially regarding evidence-based practices, including PBS. The policy development will take place at my trust and at another London organisation that is in alliance with my service. I will build partnerships with relevant networks that are local, national, and international, such as PBS Alliance and PBS Academy UK, where the findings of this study can be widely distributed. I will publish the outcome and implications of my study in the trust research newsletter that is distributed across the organisation; this will add to the body of information that I published in the early stage of my study (Appendix 16). I am also planning to set up a trust PBS faculty to bring colleagues and experts by experience together for the advancement of PBS and improvement in patients' care.

I have published part of the findings of my study in two peer-reviewed journals as detailed in Table 9 below (Savarimuthu 2019 and 2020). These articles discuss certain findings, which I have discussed and shared with the participants and also presented at the North London Forensics Consortium.

Date	Method of dissemination/practice implications	Audience
May 2018	Informal discussion with attendees at the Director of Nursing conference, Newcastle.	Regional
March 2019	Published first paper in the *Mental Health Practice Journal*. Citation is Savarimuthu D (2019). 'Positive behaviour support: exploring the experiences of nurses.' *Mental Health Practice*. doi: 10.7748/mhp.2019.e1384	International (Appendix 2)

April 2020	Published second paper in the *British Journal of Nursing*: 'The potential role of nurses in leading positive behaviour support.'	International (Appendix 1)
July 2021	Presented the study findings and recommendations at the North London Forensic Consortium Learning Disability and Autism Virtual Conference.	Regional

Table 9: Summary of how findings were disseminated.

In May 2018, I attended the National Mental Health Nurse Directors' Forum in Newcastle, UK, which was themed: 'Building capacity and impact of nursing research'. I was able to share my study, albeit informally in conversation with different professional groups including nurses and discuss its significance in mental health and learning disability services.

7.7 Conclusion

To my knowledge, and based on my literature review, to date this research is the only study that explores nurses' (exclusive) experience of PBS. Therefore, the findings provide a significant contribution to the advancement of PBS, and to supporting individuals with behaviours that challenge. This study has helped develop an understanding of PBS from a nurse's perspective (n=19) after analysis of interviews with them. The study initiated and developed a new discourse around the use of PBS from a nursing viewpoint and highlighted a few issues that need consideration for the advancement of the PBS model. The emergent themes have provided further knowledge to staff, service users and other stakeholders that are valuable for progressing PBS.

This research has provided ideas and recommendations for innovative approaches in the form of a London-wide working model, involving NHS organisations sharing good PBS practices through an online platform. This online or digital setup has the structural capacity for mental health services to discuss and shar ideas towards service improvement (NHS England, 2019). A pan-London competency document is advocated, through the online platform, for staff to use as a supporting document in the management of restrictive interventions (Mckew, 2018). This would be like the pan-London competency document that already exists for assessing nursing students (HEE, 2018) in the field of neonatal wellbeing (Rohan *et al.*, 2015). The development of a combined competency document on reducing restrictive intervention could be a worthwhile addition to this context. My study has added significant knowledge to the field of PBS as addressing challenging behaviour.

I would like to conclude by acknowledging how much research knowledge I have gained during these doctoral studies. I have extended my research abilities and skills, leading me to engage with development work, including a first initiative of a small project to improve services. This work is published as Savarimuthu and Jung (2020), and entitled, 'A quality improvement project to reduce restrictive interventions' (Appendix 17).

My second project was an investigation of ethnic minority student nurses' experience of working during the pandemic. This paper (Appendix 18) has been published and entitled, 'Covid-19: Exploring the experience of ethnic minority student nurses through a phenomenological lens' (bjmh.2021.0028). My publishing endeavour follows the line of the recently published England Chief Nursing Officer's research strategy (2021) (https://www.england.nhs.uk/publication/making-research-matter-chief-nursing-officer-for-englands-strategic-plan-for-research/) that emphasises the beneficial value of more nurse-led projects and research. An additional reason for conducting the Covid-19 project stemmed from my own experiences of working through the pandemic and dealing with my personal anxieties as an individual from an ethnic minority.

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Appendix 1: Published paper

The potential role of nurses in leading positive behaviour support.

Darren Savarimuthu

ABSTRACT

Positive behaviour support (PBS) has become the preferred intervention in the management of challenging behaviour in learning disability and mental health services. However, there is an absence of literature on nurses' views and experience of PBS. Nurses are passive in PBS plan development while other professionals, such as clinical psychologists, often take the lead. While nurses see clinical psychologists as experts in PBS, they feel this could create a barrier that hinders its full potential and a more multidisciplinary approach would be beneficial. Nurses could take a pivotal role in delivering PBS plans if they were able to take a leading role, and this would benefit service users as nurses work far more closely with them.

Key words: Positive behaviour support ■ Nursing ■ Psychology ■ Mental health ■ Learning disability ■ Challenging behaviour

Following the Winterbourne View incident in 2011, positive behaviour support (PBS) gained more attention in the care of people with challenging behaviour (Care Quality Commission, 2018). PBS is a framework that provides a structured approach to care where the dignity, human values and rights of vulnerable service users are safeguarded.

> Baker and Allen (2012) discuss PBS being an evidence-based intervention. In essence, they distinguished between PBS and applied behaviour analysis (ABA); this separation is important for the future practice of PBS (Baker and Allen, 2012). PBS is a model that ensures and maintains the human rights values of individuals, whereas ABA offers treatment interventions that can be specific to circumstances (Smith and Nethell, 2014).

A wealth of evidence supports PBS and confirms it is an extensively used model that is value based, bearing all the hallmarks that improve individuals' quality of lives (Hanley et al, 2003; LaVigna et al, 2005; 2012; Hassiotis et al, 2014). The person-focused and individualised approach of PBS makes it favoured over other interventions (Weiss and Konster, 2008). In addition, a number of studies have validated PBS as a scientific model in the management of challenging behaviour (LaVigna and Willis, 2012; Gore et al, 2013; MacDonald and McGill, 2013; McClean and Grey, 2016). Similarly, a recent study has shown wide approval of PBS by parents, who have described the practice as a positive collaborative approach to address concerning behaviour in children with complex needs (Botterill et al, 2019).

Background

While PBS is described as a multicomponent framework that is delivered through an multidisciplinary tea (MDT) approach, nurses' views of PBS were lacking in literature until recently (Savarimuthu, 2019). Savarimuthu (2019) explored the experience of six nurses of using PBS in practice.

Nurses are often seen as important players in the day-to-day implementation of PBS plans, while other professionals, such as clinical psychologists and occupational therapists (OTs) taking more of a leadership role (Davies et al, 2019). However, nurses' experience of PBS is central to how it is implemented in practice and their input potentially ensures it is delivered effectively. Nurses are well known for their abilities and skills to establish therapeutic relationship with service users. This rapport means that nurses develop a trusting relationship with service users, which has helped in engagement with them and the co-production of PBS plans. These qualities are useful in the context of PBS.

Because of nursing's troubled history, with it being seen as a vocation with training based in hospitals rather than university, it was difficult for nursing to gain recognition and validation as a profession. Being accepted as a profession is still challenging for nursing. Although nursing is now a graduate profession, nurses continue to find it difficult to explain their roles in an MDT setting (Willetts and Clarke, 2014). The discourse around nursing identity therefore remains current, especially as nurses are gradually becoming key players in the delivery of evidence based practice.

This paper reviews nurses' views of PBS in relation to it being a psychology-dominated intervention and the implications of this in current clinical practice, and their role in the future of PBS. This theme emerged in a previous study by Savarimuthu (2019).

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(2014) following the Winterbourne View incident where service users with learning disabilities and behaviours of concern were abused. PBS focuses on a functional assessment that informs the development of strategies to support individuals with complex needs.

Participants, methodology and method

Six nurses from both mental health and learning disability inpatient settings participated in semi-structured interviews.

Registered nurses were invited to take part through the email from the trust. They had to have received some for of training in PBS, have used it in practice had been involved in delivering it in mental health or learning disability services. Student nurses and other nursing trainees, nurses were unaware of PBS and non-employee bank staff were excluded.

The six participants who agreed to take part were four mental health nurses and two learning disability nurses; and four women and two men.

The interviews were each an hour long and were conducted within the trust premises to ensure meeting rooms were set to maintain confidentiality and interviews were uninterrupted.

Data were collected during the semi-structured interviews and analysed through thematic analysis.

The study used hermeneutic phenomenology as described by Heidegger and data analysis was by thematic analysis (Braun and Clarke, 2006). The hermeneutics circle as endorsed by Heidegger promotes the view that 'understanding and interpretation of [a] phenomenon is gained through shared knowledge and shared experience' (Reiners, 2012: 3).

Ethical approval was sought from the University of Salford where the author is undertaking a doctoral programme. No other ethical approval was required for this project.

Positive behaviour support

PBS is a model of care that is non-aversive and non-intrusive. It is a behavioural approach that is used in areas of challenging behaviour and was recommended by the Department of Health

Results

Six themes emerged: training; resources; psychology-led practice; restrictive practices; communication, and effectiveness (*Table 1*) (Savarimuthu, 2019). This paper explores the theme of 'psychology led-practice'.

Nurses' views of PBS

One of the six themes that was 'psychology-led practice', which had subthemes of 'clinical psychologists seen as PBS experts' and 'barriers'.

The six nurses interviewed in Savarimuthu (2019) see clinical psychologists as the experts who often lead PBS. Clinical psychologists embrace the leadership role in coordinating delivery, and the nurses felt this created tensions and challenges to team cohesion and collaborative working (Savarimuthu, 2019). This potential conflict may arise from a perception that PBS has become a psychology-dominated model mainly because of nurses being passive and too often the minions of a medically and psychologically influenced chain of command (Grant, 2001; Santangelo et al, 2018). These issues can become barriers to the effective implementation of PBS.

Clinical psychologists seen as PBS experts

Clinical psychologists are seen as the leading figures in

Table 1. Six themes arising from interviews

■ Psychology-led practice
■ Training
■ Resources
■ Restrictive practices
■ Communication
■ Effectiveness.

Source: Savarimuthu (2019)

PBS and the experts with overall dominance and influence over how PBS is plans are designed and applied. One nurse reported:

> **'[Clinical] psychologists are the leads; they develop the plans and they pass them on to the team. They are the ones who decide what to include in PBS plans.'**
>
> ***Nurse 1***

Another participant, who has a psychology background, explained that psychologists and OTs share joint responsibility in ensuring PBS is in place and is effective. PBS was described as well received by this group of highly committed nurses in clinical practice. However, nurses are seen as facilitators rather than leaders:

> **'Psychologists and occupational therapists are the main people taking a lead in PBS but nurses are very much engaged in the process in ensuring PBS is being delivered.'**
>
> ***Nurse 2***

Similarly, another was of the view that nurses are able to deliver and lead PBS provided there was adequate training:

> **'We don't have to rely just on psychologists; nurses can do this. I could go out and help put a PBS plan [in place] and in actual fact probably we are more suitable to deliver PBS—but we need to have the education'**
>
> ***Nurse 3***

Although there is recognition of the contribution from clinical psychologists' in the advancement of PBS, one nurse argued that psychologists might not be the most appropriate colleagues to take the lead; this was based on the amount of time that clinical psychologists spend with service users. Consequently, psychology colleagues may not be in a position to build therapeutic relationships as nurses would be. One participant said:

> **'Of course clinical psychologists do a good job but they come to the ward once or twice a week and see the patients for half an hour or 45 minutes and they just go off to write a PBS plan.'**

Nurse 4

When asked about their views of why psychologists are often the leading figures in PBS, one nurse said:

> **'I think purely [from my perspective] it is the training that psychologists have had. Their education helps them better understand interventions like PBS. Nurses are doers; they will get on with it by helping with the implementation of PBS. In terms of taking a lead in doing behavioural plans, it's always been the psychologist.'** ***Nurse 5***

It was claimed that behavioural approaches have always been psychologists' areas of expertise, which is why PBS is led by clinical psychologists:

> **'If you look at the current environment, [clinical] psychologists are the ones who lead on matters involving behaviours [of concern]. Psychiatrists deal with mental health issues and, us nurses, we are the one who follow the instructions, which is unfortunate.'**
>
> ***Nurse 6***

One nurse is of the view that psychologists are eager to hold high-profile responsibilities and be involved so are at the forefront of the development of PBS plans compared to nurses who are seen as passive members of the MDT:

> **'Psychologists are very willing to learn and develop strategies. Nurses are somewhat reluctant to do so. This could be because of a lack of opportunities, lack of confidence or just a lack of interest.'** ***Nurse 1***

Barriers

The second subtheme that arose under 'psychology-led practice' was 'barriers'. The majority of nurses felt there were barriers and challenges at play when using PBS:

> **'Patients were not necessarily involved in the PBS programme. By me saying this, I mean patients may have a meeting with the psychologist without the involvement of a nurse. He [the clinical psychologist] may not know what was discussed at a handover; but I think it is essential to engage nurses in the process. An absence of nurses may mean a lack of leadership from them.'**
>
> ***Nurse 5***

One nurse believes senior MDT members such as psychiatrists play an important role in deciding who should lead PBS:

> **'If we have a situation where the psychiatrist suggests nurses should take a lead, then nurses will be more engaged with this. You will find people who would want to be involved. There are a few nurses who are very good at PBS but never had the chance to be involved at that level.'**
>
> ***Nurse 6***

Comments were also made about psychologists' positions within the MDT, the role of psychiatrists and nurses' attitude and engagement in PBS. One participant reported:

> **'Once psychologists have positioned themselves as leaders—and this being acknowledged by senior members of the MDT [psychiatrists]—nurses find it difficult to become interested in or even taking the role of leader. There is a degree of unwillingness to engage. This is not necessarily being unprofessional but there is a lack of cohesion.'**
>
> ***Nurse 2***

Psychology-led practice

The six participants who took part in this study (Savarimuthu, 2019) described PBS as a psychology-dominated intervention. Nurses from the study perceive clinical psychologists as experts in PBS, but they feel this could create a barrier that hinders the full potential of PBS. The discourse that clinical psychologists are seen as leaders of PBS may have stemmed from the origin of PBS (Carter et al, 2011). PBS was initiated with a psychological backdrop in both the US and UK (Positive Behavioural Support (PBS) Coalition, 2015). Bambara et al (1994) epitomised the original use of PBS initially driven by psychologists in a school environment where they were supporting teachers who in turn were supporting children with challenging behaviour.

Nurses may have developed some resistance because PBS is a psychological framework but have remained central to its development and practice. However, clinical psychologists are seen to be taking prominent roles in developing PBS plans and leading its delivery in current practice. In such a case, there is the perception that PBS is applied through a top-down approach with nurses often finding themselves at the lower end of the hierarchy, seldom giving the primary role of monitoring how the plans are working.

Interestingly, nurses view clinical psychologists as an unknown group whose input in providing healthcare is uncertain (Osborne-Davies, 1996). Furthermore, clinical psychologists have been described as occasional workers with indeterminate roles who have momentary contact with service users (Saar and

Trevizan, 2007). Undoubtedly, some of these observations have impelled nurses to think it is appropriate that clinical psychologists work in partnership with the nursing team alongside service users to co-produce PBS plans rather than working in silos (Ham and Davies, 2018).

Nevertheless, there are arguably positives of having one profession assigned to lead PBS. One benefit is around achieving consistency from having one profession deliver the practice (Gore et al, 2015); this is an important consideration as otherwise PBS runs the risk of failure, particularly if there is a lack of co-ordination or communication between different professions (PBS Coalition, 2015). However, an MDT approach is helpful because sharing knowledge and expertise across disciplines is valued (Webber et al, 2017). A salient component in the successful implementation of the PBS model is through a constant MDT presence in areas where it is being practised. This argument is supported by Nancarrow et al (2013), who believe PBS should be practised in a way that crosses interdisciplinary boundaries. The participants in Savarimuthu (2019) also referred to the importance of teamworking and, in their view, working in collaboration with professionals from diverse occupations is important and beneficial, particularly as clinical psychologists may only have occasional contact with service users. Nurses wish to be actively involved and, at best, lead as they interact with service users on a day-to-day basis (Pazargadi et al, 2015).

Professionals other than clinical psychologists are already involved in PBS, including school teachers, social workers and OTs (Perez et al, 2012). Therefore, although PBS remains mainly psychology led in clinical practice (Dunlap, 2006), it is now evident that leaders of the framework incorporate other disciplines. Perez et al (2012) establish the importance of OTs in the implementation of PBS, claiming that because challenging behaviour may be caused by a number of factors such as social challenges, sensory modulation challenges and skills deficits, the role of OTs is relevant in addressing these behaviours of concern (Webber et al, 2017). Correspondingly, OTs have positioned themselves in a leading role. Similarly, social workers are recognised as implementers of PBS (Leyba, 2010), and the role of speech and language therapists in PBS is now well documented (Webber et al, 2017). It is nurses' position as leaders with regard to PBS that remains unclear.

Nurses need to embrace the PBS model and it is crucial that they feel a sense of belonging with the concept (Karger et al, 2018). This is important step that would ensure a the could take on a leadership role in a smooth, realistic way. In cases where PBS has been successful, there has been a notable commitment from staff to advocating for it while creating opportunities for PBS to succeed through a collaborative working approach (Ham and Davies, 2018).

Recommendations for practice

Nurses have reported teamworking and consistency as two essential requirements for PBS to work and deliver its objectives. Teamwork is very dependent on having both adequate staff and a workforce that has the right skills and competences. Therefore, training is a key determinant in PBS delivery.

In addition, the nurses in this study referred to the benefit of working with service users and the contribution of the MDT. This collaborative working is useful in the implementation of PBS plans, as the approach requires input from different fields of expertise Consistency is viewed as fundamental to successful PBS delivery. The participants described the implications of an inconsistent approach and the impact of this on service users and the care provided to vulnerable people. To ensure consistency and the best outcome in the delivery of PBS, a co-produced approach is preferred. This would mean service users, carers and experts by experience would make a significant contributions to the decision-making process.

Table 2: Areas for further development	
Leadership	Nurses should be empowered to take leadership roles in the practice of positive behaviour support (PBS) and to lead research that informs their understanding of the model. NHS organisations should consider a model of consumer leadership where service users are engaged in PBS implementation.
Training	PBS training needs to be offered to all staff, in particular nurses, so they are equipped to lead the intervention.
Collaborative approach	Clinical psychologists, occupational therapists and nurses need to work in partnership with service users.
Co-production	Service users are indubitably the primary stakeholders in any intervention and nurses are best placed to engage them in co-designing PBS plans.
Resources	Recruitment and retention of nurses is a national issue. NHS organisations should work together to develop strategies so that nursing resources are distributed and used appropriately.

For PBS to be effectively practised and for service users to enjoy the full benefit of the practice, some areas require further exploration and some of these are highlighted in *Table 2*.

Nurses are considered key players in PBS practice by virtue of their proximity to service users and by often being the frontline staff who deal, manage and be with victims of violence and aggression (Dickens et al, 2013).

These are some of the arguments for nurses to be given opportunities to be empowered to take an active role in leading PBS (Griffiths and Wilcox, 2013). The essence of nursing has meant that nurses have become important stakeholders in the care delivery of service users rather than merely implementing plans (Santangelo et al, 2018). Similarly, while clinical psychologists in general are observed to be more open to collaborative working and often offer an alternative to the dominant medical model (Christofides et al, 2012), they have shown great leadership in PBS field; this may have side-lined nurses.

While various factors affect and influence teamworking, hierarchy, power and individual characteristics are some of the dominant themes (Jones and Jones, 2011; Fox and Reeves, 2015; Sims et al, 2015). Nurses and clinical psychologists will therefore need to share responsibilities and accountability towards collaborative working for PBS to succeed (Karger et al, 2018). However, there should be also be a recognition that nurses need to take a leading role in the delivery of PBS.

Conclusion

There is strong evidence that it is important for nurses to take a leading role in the management of challenging behaviour through the facilitation of PBS. Indeed, systematic preparation and training of nurses in PBS are necessary steps to encourage much more engagement from this professional group.

In the current landscape, another issue requires further consideration; for nurses to be able to have a greater involvement in PBS, healthcare organisations need to provide the resources so that nurses have the flexibility to take on the role of PBS practice leaders. Extra resources could release nurses from some of their current responsibilities (Redknap et al, 2015). This could be a senior nurse being given protected time off their clinical duties to take on the role of PBS coordinator or PBS champion.

KEY POINTS

- Positive behaviour support (PBS) plans are often delivered by nurses but their development is led by clinical psychologists.
- Nurses should embrace roles as leaders and be an assertive profession for the effective implementation of evidence-based practice including PBS.
- Nurses and clinical psychologists should work in partnership for PBS to be successful.
- PBS training and service user engagement are important imperative prerequisites for its delivery.
- Communication, teamworking and consistency within an MDT is vital to PBS delivery.

As with any piece of research, this study has its limitations, starting with the sample size. However, there is a paucity of research exploring nurses' experience of PBS so the views of a small number of nurses are a valuable contribution.

Exploration of a community-based PBS could be useful to fully appreciate the practice. Equally significant would be an investigation of other professionals' experience of PBS. These may include nursing associates, healthcare assistants and graduate mental health workers, as they are all actively involved with the model. **BJN**

Declaration of conflict: none

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CPD reflective questions

- Are you and your colleagues aware of the positive behaviour support (PBS) competency framework devised by the British Institute of Learning Disabilities?
- How would you engage service users in the development and implementation of PBS plans?
- Have you considered the role of PBS in any quality improvement projects to reduce restrictive interventions within your service?
- What measures could you put in place to empower nurses to lead on PBS implementation?

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Appendix 2: Published paper

Mental Health Practice

evidence & practice

Positive behaviour support: exploring the experiences of nurses

Darren Savarimuthu

Key points

- *Nurses feel there is a lack of PBS training in health organisations*
- *The current acute shortage of staff has implications for the delivery of PBS*
- *PBS is largely led by clinical psychologists, which can be a barrier to nurses providing PBS*
- *Effective communication is one of the essential constituents of delivering effective PBS*
-

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Abstract

Background
Positive behaviour support (PBS) has become an important and useful framework in the care of patients with challenging behaviour. However, there is a lack of evidence that explores nurses' experiences of PBS in clinical practice.

Aim: To explore the experiences of nurses using PBS to contribute towards the existing body of evidence on PBS.

Method: Six registered practitioners comprising of four mental health and two learning disabilities nurses were interviewed using semi-structured interviews. The data was analysed by hermeneutic phenomenology and themes were developed through thematic analysis.

Findings: Six themes were identified: training; resources; psychology-led practice; restrictive practices; communication; and effectiveness. Nurses described PBS as an effective framework in the management of challenging behaviour and identified appropriate communication and leadership as essential elements.

Conclusion: There are a lack of resources that can potentially compromise the delivery of PBS. It was observed that the PBS framework is mostly psychology led, however, nurses often find themselves in the forefront of challenging behaviour and should be encouraged to take a lead in the formulation of PBS plans and their delivery.

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Keywords

communication, learning disability, mental health, phenomenology, positive behaviour support, research

Introduction

In the UK, inquiries into the Winterbourne View Hospital (Department of Health (DH) 2012) and the Commission for Healthcare Audit and Inspection (2006, 2007) suggest an urgent need to improve the care of people with challenging behaviour despite the difficulties in the commissioning of services. In 2011, an undercover reporter visited the Winterbourne View Hospital following concerns of poor care and abuse that were raised by a nurse at the hospital; the reporter's findings were shown on the BBC Panorama programme, which then became known as the Winterbourne View scandal (BBC 2011). The programme depicted the physical, emotional and psychological abuse of vulnerable service users who had learning disabilities and displayed challenging behaviour.

In 2011, as a result of the incident at Winterbourne, the DH commissioned a nationwide consultation on the development of new guidance to reduce restrictive practices in health and social care [AQ see notes]. It also prompted the DH to issue important policies and guidance urging care providers to endorse interventions that are the least restrictive, most sustainable, and with long-lasting benefits. Similarly, the Royal College of Nursing (RCN) has been actively involved in requesting views from its members on the employment of least restrictive strategies in the effective management of challenging behaviour (RCN 2014).

Positive behaviour support (PBS) is a behavioural approach that is non-aversive and less intrusive; it is a powerful model that provides a systematic intervention consisting of appropriate measures in cases where there are behaviours of concerns (Padden 2016). The PBS tool or framework is composed of primary and reactive strategies. The primary strategies put emphasis on changing unwanted behaviours while the reactive aspect of the framework provides a process of managing challenging behaviours when they occur. Therefore, unlike other behavioural strategies, PBS has its main focus on stopping behaviour from taking place by understanding why a particular challenging behaviour happens in the first place (function of the behaviour) and what the triggers are for the behaviour. PBS is used to help manage these triggers and supports people by understanding the reasons for a particular behaviour and to make use of that knowledge to actively support them (NHS England and Local Government Association 2014).

In the mid-1980s, PBS became a recognised intervention in the UK as a result of growing concern about the use of inappropriate and restrictive approaches for the care of service users with challenging behaviour who required specialist support (Meyer and Evans 1989, DH 2015, National Institute for Health and Care Excellence (NICE) 2015). An initial attempt to define PBS was made by Horner in the 1990s (Horner et al 1990, Crone et al 2015), who described PBS as a non-aversive behaviour management framework. This first definition comprised certain characteristics such as functional assessment, lifestyle changes and minimising aversive techniques. The primary objective of embracing PBS in the UK was to offer a set of interventions that were safe, socially acceptable and effective, with long-term benefits focusing on community living (Horner et al 1990, DH 2015). Restrictive practices are activities or actions that could be intentional or unintentional and are defined by the DH (2014a) as:

'Making someone do something they don't want to do or stopping someone doing something they want to do.'

Gradually, PBS has become a popular model in the care of people with challenging behaviours both in learning disability and mental health services (Carr et al 1999, NICE 2015, Davies et al 2016). There is an abundance of research evidencing the benefits of PBS in improving the quality of life of those who receive it (Hanley et al 2003, LaVigna and Willis 2005, Grey and McClean 2007, Allen et al 2012, LaVigna et al 2012, Griffiths and Wilcox 2013, Jones 2014). One of the characteristics of PBS is that it provides an individualised approach to challenging behaviour, and this makes it a much-preferred model compared to other interventions. However, during a literature search it was found that there is a deficiency

in current data espousing nurses' views and experiences of PBS. This gap in the evidence base may have a potential effect on practice, especially when nurses are often in the fore of care delivery implementing PBS. The author believes that nurses' experiences of PBS hold great importance for the future implementation and development of the practice.

The DH (2014a) and the Care Quality Commission (2016) have advised both mental health and learning disability services to show a commitment to employing PBS, to evidence the presence of appropriate support plans towards addressing challenging behaviour, and for health services to ultimately work towards significantly reducing restrictive practices. Consequently, a better understanding of nurses' experiences of using PBS may potentially assist in future training needs analysis, and further support the development of appropriate plans in the advancement of PBS.

Positive behaviour support is widely practised in specialist schools, but it has gradually gained recognition in the healthcare environment as a proactive strategy (Dunlap et al 2009). As the framework is further researched and tested, it has been identified as an effective, reliable and promising intervention in mental health services (Griffiths and Wilcox 2013). Some of the already available literature on PBS includes the implementation of PBS in forensic mental health (McDonnell 2010, Davies et al 2016), clinicians' PBS training needs analysis (DH 2014b) and an appraisal of the effectiveness of PBS in care settings (Ridley and Jones 2012). Gore et al (2013) simplified the features of PBS for the benefit of those who intend to use the framework, as well as to guide the development of policies and to support future research initiatives on PBS. The main components of PBS are:

- Values.
- Theory and evidence based.
- Process.

The value aspects of PBS ensure that people are treated with respect and dignity and emphasis is put on improving quality of life. The theory and evidence-based component guarantees that PBS is informed by the latest research and data and the intervention is data driven. The main tenets of the framework encourage a continuous and ongoing functional assessment that informs the delivery of PBS plans. It also captures essential data that helps to ascertain which strategy and approach to adopt during PBS implementation. In 2016, Davies et al refined the definition of PBS by suggesting that the framework is a multicomponent approach that comprises ethically-sound and socially-acceptable intervention for dealing with challenging behaviour.

Literature review

An initial literature search was undertaken by carrying out a scoping exercise using Google Scholar and Google, which are described as the most extensively used search engines with a total of 67.3% of all searches done through Google worldwide (Younger 2010). From the literature that was discovered, the associated reference lists were analysed, based on their relevance, to search for any other work that made reference to nurses' experiences of PBS or any other relevant literature on PBS (Hart 2012, 2018).

The databases Cumulative Index to Nursing and Allied Health Literature, Medline, PsychINFO and PsychNet-UK were searched with the following terms, as guided by Hart (2012) and Aveyard (2010): positive behav* support/experience and positive behav* support/review. The content lists of the Journal of Positive Behavior Interventions, the Journal of Applied Research in Intellectual Disabilities and the International Journal of Positive Behavioural Support were reviewed because they are current PBS specific journals. Table 1 shows the common themes of the literature search.

Table 1. Emerging themes from literature search

Themes	Description
» Benefits of positive behaviour support (PBS in learning disabilities and mental health.	» PBS is widely used in learning disability settings and gradually becoming a preferred intervention in mental health services.
» Staff perception of PBS.	» Multidisciplinary team.
» Evidence-based practice (suitability of PBS in healthcare practices).	» PBS is a scientific approach.
» Perceived limitations of PBS.	» PBS is associated with applied behaviour analysis hence has attracted some criticisms.
» School settings.	» PBS is widely used in specialist schools.

Aims

The aim of this study was to explore nurses' experiences of using PBS and achieve the following three objectives:

» Generate new knowledge and contribute towards the existing body of evidence on PBS.

» Explore how the findings of the study will have potential implications for learning disability and mental health services.

» Fill the gap in current literature that explores nurses' views and experiences of PBS.

Method

Hermeneutic phenomenology facilitates greater understanding of the data while simultaneously allowing the researcher to 'exist' in the participant's world and being (Ho et al 2017). Heidegger's version of hermeneutic phenomenology was the best fit for this study as it helps to provide an understanding of a human's lived experience of a particular phenomenon while analysing and exposing the meaning of that experience (Salmon 2012). Although hermeneutic phenomenology is similar to phenomenology in exploring the person's lived and human experience, the difference lies in the way the lived experience is analysed. Heidegger focuses on 'Dasein', which is best described as the mode of being human (Laverty 2003, Crowther et al 2017). He further explains hermeneutics as another way of achieving a sense of understanding, while the understanding of a particular phenomenon is linked to an already established array of compositions (Koch 1995, Laverty 2003, Horrigan-Kelly et al 2016). The main aspect of Dasein, according to Heidegger, is the exploration of lived experiences of individuals and their interaction with the world, and these can only be accessed and understood through interpretation (Smith et al 2009).

Participants

Six registered nurses took part in the study: four mental health and two learning disability nurses. They had some awareness of PBS, either through training or having implemented PBS in their current or previous clinical environment.

Data collection

Data was collected during semi-structured interviews and analysed through thematic analysis (TA) which, in connection with hermeneutic phenomenology, involves an approach that is deductive. This means any interpretation of data had considered previous literature searches on PBS, including the author's own experience and interest in the subject (Braun and Clarke 2006). While there are different methods of collecting data in phenomenological research (van Teijlingen and Ireland 2003, Sloan and Bowe 2014), semi-structured interviews are often described as both adaptable and powerful qualitative research methods for data collection (Galletta 2013). In this study, engaging participants in semi-structured interviews was valuable because of the interface aspects of the interactions (Murray et al 1994, Doody et al 2013). During the interviews, the author used his prior knowledge of PBS to explore the stories told by the participants, a process which ensured all aspects of their accounts were fully valued, investigated and understood.

Data analysis

The data analysis was done through TA, which comprises six stages (Braun and Clarke 2006):

- Data familiarisation.
- Generating initial codes.
- Searching for themes.
- Reviewing themes.
- Defining and naming themes.
- Producing the report.

The thematic process involved producing a list of what transpired from the transcripts followed by the formation of codes.

Ethical considerations

Approval for this study was obtained from the University of Salford, Manchester, where the author is undertaking his doctoral programme, and registered with the research and development department and the quality assurance department of Enfield and Haringey Mental Health NHS Trust. The author followed the RCN guidance on research ethics (RCN 2011) and the principles of the Research Governance Framework (DH 2005).

Findings

Six themes emerged from the data analysis and are listed in Box 1.

Box 1. Emergent themes

- Training
- Resources
- Psychology-led practice
- Restrictive practices
- Communication
- Effectiveness

Training

Participants emphasised the importance of appropriate PBS training to increase their awareness of the framework. The nurses described training as being fundamental in the efficacy of PBS, particularly towards maintaining consistency in the delivery of the approach and in staff development. While training is viewed as essential in enhancing confidence, providing the authority to lead, and facilitating the implementation and delivery of PBS, it is also found to foster professional identity (Stocks and Slater 2016). This is important for nurses as clinicians because they feel they have an important role in the development of strategies to reduce challenging behaviour through the application of PBS (Mansell et al 2010).

The nurses in this study felt that training in the field of PBS remains limited and that the multidisciplinary team requires training on PBS for the model to be effectively practised. However, it is argued that PBS training should become an integral part of pre-registration nurse training:

'It is a lack of training, because people are not well trained to be shown how to implement the framework, this is how we should follow this to support particular clients' (Participant 1).

'It would not really matter whether the training is in house or external as long as it is extensive and practical. A training that is enough to empower nurses to not only understand the process of PBS but also to be able to lead a team to deliver it' (Participant 6).

Participants suggest that student nurses' exposure to PBS should not be left to chance but should be embedded in their education. The findings of this research emphasise the need for mental health and learning disability nurses to have a good grounding knowledge of PBS with an adjustment to the current nurse education curriculum.

Resources

Participants expressed their views on the necessity to have the correct resources for PBS to work, the need to work in a team and to be consistent. Resources of properly trained staff and the appropriate number of staff are proposed as elementary to the good functioning of PBS. Therefore, effectiveness and success of PBS can be directly linked to resources and being consistent in approach. The participants provided narratives of their PBS experiences in the context of a nationwide struggle with recruitment and retention of nurses in healthcare services (Lasala 2017). The nurses felt that a lack of staffing in front line nursing has had a significant negative effect on the success of PBS in their work areas. Although the participants acknowledged the effectiveness of PBS, they felt it was important to have enough nurses in areas where PBS is implemented for the process to be effective. Inevitably, the existing acute shortage of nurses will have a direct effect on the way in which interventions such as PBS are delivered (Buchan et al 2015). One nurse commented:

'We need consistency, continuity and effort from each and everybody within a team for the intervention (PBS) to work' (Participant 6).

Correspondingly, nurses who work in challenging environments tend to leave their job quicker than their peers (Cleary 2004, Selmon et al 2017), so any long-term PBS intervention will be greatly compromised if the recruitment of nurses remains problematic (Buchan et al 2015). The RCN (2017) published a report on the current nurse shortage crisis in the UK,

with a decrease in the number of nursing students entering professional training (House of Commons Health Committee 2018).

Psychology-led practice

All participants described PBS as a psychology-dominated intervention; the nurses perceived psychologists as experts in the field, which could form a barrier to the success of PBS. The argument that psychologists are seen as the main actors in PBS can be explained by its origins (Carter et al 2011). Bambara et al (1994) epitomised the original use of PBS as driven by psychologists in a school environment where psychologists were supporting teachers to work with children with challenging behaviour.

Clinical psychologists have a lot of input in PBS compared to other professions (Karger et al 2018), however, the outcome of this study was that the participants wished to lead PBS in practice:

'We don't have to rely just on psychologists; nurses can do this. I could go out and help put a PBS plan [in place] and in actual fact probably we are more suitable to deliver PBS; but we need to have the education' (Participant 5).

'Of course clinical psychologists do a good job but they come to the ward once a week or twice a week and see the patients for half an hour or 45 minutes and they just go off; and they go and write a PBS plan' (Participant 3).

Restrictive practices

This study suggests that there could be a link or correlation between PBS, challenging behaviour and restrictive practices. PBS is seen by nurses as a model that reduces restrictive interventions, which is in line with the human rights agenda, particularly following the Winterbourne incident, and has some influence on challenging behaviour. PBS also helps to reduce the effects of power and control on service users and it creates a channel where service users are cared for in a less restrictive environment. This study demonstrates that an effective PBS plan can potentially help staff understand challenging behaviours hence creating real opportunities to improve the care of patients. During the interviews, restrictive practices became an overarching theme in connection with PBS:

'So, PBS focuses on least restrictive practices as our feeling is that if someone present as challenging then they are so for a reason. So, it's not about being punitive or taking away any privileges. It is more about working with that person to look at other ways to ask for things or deal with situations' (Participant 6).

Communication

Appropriate and consistent communication has a significant influence on the successful application of PBS (Webber et al 2017). The majority of participants strongly believed in a consistent PBS approach and a clear flow of communication among staff and between staff and service users. Similarly, leadership in practice is considered indispensable in PBS (Beadle-Brown et al 2012, PBS Coalition 2015, Webber et al 2017). Leadership from senior managers and other senior staff working in roles where there is direct contact with service users is deemed decisive in upholding PBS standards and achieving positive outcomes (Beadle-Brown et al 2012). In this study, leadership was referred to as the support that staff received during the implementation of PBS, coaching and modelling, one-to-one supervision support and team meetings where PBS support was discussed:

'So, what I would do is make sure the team is communicating well, delegate properly, i.e. support workers, key workers, monthly meetings, fortnightly meetings, to then discuss how is it working, what do we need to do, delegating to other staff and engage in team effort' (Participant 5).

'I think PBS works, it has worked but yet I think it was not communicated well to the staff' (Participant 3).

Effectiveness

Nurses accepted that PBS may not be an intervention that eliminates challenging behaviour, instead it is geared towards improving the quality of life of service users and treating them with respect and dignity. The participants identified PBS as a useful framework which provides sustainable means of putting measures in place to deal with inappropriate and unacceptable behaviour, or behaviours that challenge, but also in supporting service users who may be susceptible to developing complex needs in the future (PBS Coalition 2015). In more serious cases, PBS will work alongside other

interventions in a care package, with the aim of addressing challenging situations. There may be service users who lack mental capacity, those who are detained under different sections of the Mental Health Act 1983 (DH 2015) and others who may be acutely unwell to engage in co-producing their care pathways. One participant commented:

'I think with PBS it's about looking at the bigger picture and see how we can as nurses, as support workers get to understand the client and see how our actions, how the environment interacts with that client' (Participant 5).

Discussion

This qualitative study has highlighted the benefits of PBS in supporting challenging behaviour, which is well established in various studies (Griffiths and Wilcox 2013, Davies et al 2016). Another theme that is consistent with existing literature is the need for PBS training. PBS is a relatively new approach in the UK, so nurses wish to fully appraise the values of the model and be aware of how these could be applied to dealing with challenging behaviour. Therefore, PBS training has to be appropriately delivered by suitably qualified staff. Equally, there are a number of university-based training programmes on PBS which can be accessed by healthcare organisations. While training remains one of the major elements that would decide the fate of PBS, creating an awareness of the intervention is an important step. Staff may not be enthused by PBS if the concept remains vague or unfamiliar; health services need to think widely and be realistic about the challenges and barriers to delivering PBS.

Nurses are important in PBS implementation because they are among the front-line staff who de-escalate and often become victims of violence, aggression and other challenging behaviours. This is one of the reasons for nurses to be more engaged in the administration and organisation of PBS. A purely psychology-led intervention carries the risk of meeting resistance and lack of interest from other professionals, particularly from nurses. It is known that nurses are exceptionally skilled at building therapeutic relationships with service users (Cockerton et al 2015) and this expertise can be beneficial in the integration of PBS in care plans. A better collaboration and communication among various professionals including clinical psychologists may provide nurses with an opportunity to develop into competent PBS facilitators. It is important that nurses are encouraged to take on the role of enablers of PBS in correlation with the future management of challenging behaviour, but also for the development of any local PBS framework.

As indicated by Karger et al (2018), having the appropriate resources in a clinical environment is imperative for the effective delivery of PBS. The current critical shortage of nurses can potentially compromise the delivery of PBS, which subsequently runs the risk of being pushed aside in the face of all other competing priorities in healthcare systems. Nurses remain pivotal in the appraisal, monitoring and administration of PBS, and healthcare organisations need to re-think about how to train more staff so that PBS is not restricted to only registered nurses and clinical psychologists. The preparation of training nurses will require a co-ordinated and multi-pronged approach but will be a significant investment that demonstrates a commitment towards the reduction of restrictive practices and the long-term support of challenging behaviour.

While PBS remains a credible and effective framework in dealing with challenging behaviour, it is equally imperative that other interventions are carefully applied, for example, the use of medication, especially when the behaviour is characterised by an underlying mental health condition. Pharmacological approaches and behavioural interventions have often been used to manage challenging behaviour although there is not enough evidence that explores the interaction between psychopharmacology and challenging behaviour (Cox and Virués-Ortega 2016). However, in a study by Zarcone et al (2004), thirteen participants with behaviours of concern were studied during a time when they were given the antipsychotic medication of risperidone. The findings suggest that risperidone may have some positive effects towards minimising the unwanted behaviour. However, the use of medications in situations of challenging behaviour remains an ongoing debate.

Limitations

A larger sample including non-registered nurses could have given a wide-ranging view of PBS in clinical practice and their experience and views of the framework could have further helped understand the broader issues around the full implementation of PBS in mental health services. Non-registered nurses, support workers, associate nurses, graduate mental health workers and assistant practitioners are taking on more clinical responsibilities so their views are extremely important

in the implementation of a gradually becoming widespread practice. There is a similar argument for nursing students who assume important roles during their rotational clinical placements and therefore their experience of PBS is valuable.

Service users remain the main stakeholders in any clinical intervention that forms part of their treatment plans, and engagement with service users ensures co-production of care. It would be beneficial to seek their views and experience of PBS while the practice is part of their care plan. The findings could inform PBS leaders to involve significant others in addressing concerns and issues from a service user's viewpoint.

Conclusion

This study has provided a contribution to the existing body of evidence on PBS through the exploration of nurses' experiences of using the framework in practice. Nurses in the study were unanimous in highlighting the effect of an acute shortage of resources on the delivery of PBS and an increase in the use of restrictive practices. To address these challenges, services will need to invest in appropriately qualified staff; training has to be practice focused involving experts by experience rather than being purely theory based. Nurses often find themselves in the forefront of challenging behaviour and should be encouraged to take a lead in the formulation of PBS plans and their delivery.

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Appendix 3: List of 14 research and its critical appraisal

Author / Date	Methodology/Methods Sample	Aims	Findings	Quality Score (CASP/MMAT)	Critical appraisal/ Limitations	Comments
Bambara et al (2001)	Qualitative; grounded theory, constant comparative method; semi-structured interviews. 19 participants: community-based staff with > 1-year PBS experience.	To identify staff experience of delivering PBS to adults with learning disabilities and challenging behaviour.	Themes; support; values. A need to better understand behaviour.	18/20 CASP 90%	Benefits of PBS in learning disabilities and mental health. Inadequate presentation of families Short period of data collection (3 weeks).	Staff experience
Lowe et al (2007)	Questionnaires (pre and post training) of 205 staff. Attitude=122 (reg.=70, non-reg.=52; 2/3 F) Knowledge=205 (reg.=101, non-reg.=104; 69% F)	Assessment of attitude and knowledge of nursing staff (reg. and non-reg)	Significant improvement on knowledge and confidence but little effect on emotional response.	11/28 CASP 39%	Did not evaluate the effect on QoL 1 year follow up Attrition rate high Full data set not available.	Training on attitude and knowledge
McGill et al (2007)	Questionnaires 79 students (1998–2000) University-based training	To collect information about the impact of extended PBS training support on staff knowledge, causal attributions and emotional responses.	Knowledge improved and attributions and emotional responses too.	16/28 CASP 57%	Statistical comparison made but not displayed.	Training on knowledge

Lohrmann et al (2008)	Qualitative; semi-structured interviews; grounded theory; method of open coding. 14 educational consultants PhD=10 Masters=4	To highlight staff observations and narratives of barriers to effective PBS implementation in school-wide settings.	5 barriers emerged: leadership; hopelessness; scepticism; security and comfort.	18/20CASP 90%	Staff involvement in PBS Small sample No school staff interviewed.	Staff experience on barriers
Bambara et al (2009)	Qualitative; semi-structured interviews. 25 participants (External facilitators=4, parents=5, teachers=6, admin=5, internal facilitators=5) (F=22, M=3)	Exploration of team experience of the barriers to PBS in school environments. Teachers, school administration staff.	Themes: culture of the school; leadership; development; engagement and involvement.	17/20 CASP 85%	PBS in school settings Staff involvement in PBS Some themes were general rather than school specific.	Team experience/ school
Perez et al (2012)	Semi-structured interviews; thematic analysis. 10 OTs PBS exp. 3 months–26 years	To explore activities and experiences of OTs working with PBS	Themes: understanding behaviour; challenges; support.	18/20 CASP 90%	Staff involvement in PBS. Sample size- only 10. Self-selected sample so could be bias.	Experience of OTs
Lohrmann et al (2012)	Qualitative; grounded theory; constant comparative method. 9 participants x2 Paired internal and external coaches (9x2).	Identifying issues faced by stakeholders. i.e. internal and external coaches	Themes: change in system; barriers; support	11/20 CASP 55%	Evidence-based practice Perceived limitations of PBS Findings not specific to any school No school perspective sought A more structured recruitment would have a wider sample of coaches (participants).	Stakeholders' views/school

Woolls et al (2012)	Qualitative; grounded theory; semi-structured interviews and 1 focus group. 8 staff for interviews (reg.=3, non-reg.=1, social care mg.=1, support worker=3) (F=6, M=2) 6 for focus group (Indirect care staff of behaviour specialist=4, clinical psych=2) (F=5, M=1)	To ask staff their perspective of what is supportive and problematic while delivering PBS in areas of learning disabilities and challenging behaviour with individuals.	Five themes: 'service delivery'; 'external support'; 'internal support'; 'mediators'; and 'delivery of PBS'.	13/20 CASP 65%	Staff involvement in PBS Generalisability of the research restricted due to small sample Focus group 6.	Staff perspective
Wills et al (2013)	Self-report questionnaire based on a single case study of LD patient. 59 care staff (M=22, F=37) 38 only post-training measurement.	Evaluate staff knowledge, attributions and emotional responses following PBS training.	Inferential statistics, pre and post training (5.05 to 6.82) Knowledge $P<0.001$ Causes of behaviour $P<0.05$ Proactive help $P<0.001$ Optimism $P<0.05$.	16/28 CASP 57%	Attrition rate n=38 No follow up Validity (case study- artificial) Questionnaire short to minimise completion time. Behaviour cannot be translated into practice. No control for comparison used.	Positive impact on knowledge and attributions.

Inchley-Mort and Hassiotis (2014)	Qualitative; semi-structured interviews; content analysis. Complex behaviour service 25 carers: 8 family carers (all mothers), 9 paid carers, 3 managers of supported living accommodation, 5 professionals care managers. (F=17, M=8) 6 service users (mild LD) (M=5, F=1)	To investigate PBS stakeholders experience of PBS in a specialist service.	Themes identified availability and frequency of contact; talking about behaviour and being listened to; being understood; change; longer engagement and crisis support; and challenges.	16/20 CASP 80%	Evidence-based practice. Convenience sample so findings cannot be generalised. Service users may choose not to be critical to service. SU spoke less when being recorded. Carers stayed with SU hence may have influenced outcomes.	Stakeholders experience/ including service users.

Andreou et al (2014)	Qualitative, semi-structured interviews, critical incident technique (derived from phenomenology). 17 educators (admin.=4, consultants=4,teachers=3, general teacher=6) (F=12, M=5) School has used PBS for 10–14 years.	An exploration of school perspective in relation to school-wide PBS implementation.	13 categories: Continuous Teaching, Positive Reinforcement, SWPBIS Team Effectiveness, Staff Ownership, School Administrator Involvement, Adaptation, Community of Practice, Use of Data, Involving New Personnel, Access to External Expertise, Maintaining Priority, Staff Turnover, and Conflict of Personal Beliefs/Mistaken Beliefs.	18/20 CASP 90%	Heavy reliance on retrospective self-report. PBS in school settings.	School perspective
Karger et al (2018)	Qualitative, thematic analysis. 11 semi-structured interviews of MDT (RMN=2, WM=2, HCA=2, Psychiatrist=1, OT=1, OT Tech=1, specialist trainee psychiatrist=1, clinical psychologist=1) (F=6, M=5) 6–24 months training	This paper explores the perception of MDT staff in the application of PBS in a secure mental health service	Five themes emerged: The functions, appraising new approach, collaborative challenges, staff variables and organisational issues.	13/20 CASP 65%	Staff involvement in PBS. Small sample for thematic analysis. Lack of professional homogeneity.	MDT staff perception

Clark et al (2020)	Mixed methods Interviews/thematic analysis and quality completion rating (Quality of PBS plans completion). 7 relatives (F=6, M=1) 13 nurses (F=6, M=7) Male PICU	Evaluate PBS in a mental health inpatient service; understand mental health nurses' and relatives' attitudes to them; understand the barriers and facilitators.	Two broad themes emerged: understanding and awareness of restrictive practices; PBSPs as an aid to patient care.	22/30 MMAT 73%	Nurses were only RMNs. No views from SU. Small sample for this type of study. Interviews 15 mins–1 hr. Not tested attitude re restrictive practices. QoL.	RMN evaluation
Houchins et al (2005)	Qualitative; grounded theory; focus groups; constant comparative analysis. Juvenile setting. 22 staff (F=14, M=8) (admin=6, teacher=9, clinical staff=7)	Stakeholders' view of PBS so to identify themes that are consistent within a juvenile justice environment.	Themes: Ecological congruence, role clarify, philosophical shift/agreement, cache of proactive/ preventative strategies, consistent practices, logistics, data-based decision making, achievement outcomes.	16/20 CASP 80%	Perceived limitations of PBS Small sample for focus group Reliability/validity.	

HCA=healthcare assistant, reg.= registered nurses, non-reg.= unregistered nurses, admin.= administrative staff, M=male, F=female, SU= service users,

Quantitative studies

Articles →	**Lowe et al.,2007**	**McGill et al., 2007**	**Wills et al., 2013**
1. Question/objective sufficiently described?	No	Yes	Yes
2. Study design evident and appropriate?	Yes	Yes	Yes
3. Method of subject/comparison group selection OR source of information/input variables described and appropriate?	Yes	Partial	Yes
4. Subject (and comparison group, if applicable) characteristics sufficiently described?	Partial	Yes	Partial
5. If interventional and random allocation was possible, was it described?	NA	NA	NA
6. If interventional and blinding of subjects was possible, was it reported?	NA	NA	NA
7. If interventional and blinding of investigators was possible, was it reported?	NA	NA	NA
8. Outcome and (if applicable) exposure measure(s) well defined and robust to measurement/misclassification bias?	NA	Partial	No
9. Sample size appropriate?	Yes	Partial	Partial
10. Analytic methods described/justified and appropriate?	No	Partial	Yes
11. Some estimate of variance is reported for the main results?	No	Yes	Yes
12. Controlled for confounding?	No	No	NA
13. Results reported in sufficient detail?	Yes	Yes	Yes
14. Conclusions supported by the results?	Yes	Yes	Yes
Quality Score (out of 28)	**11**	**16**	**16**

Mixed method

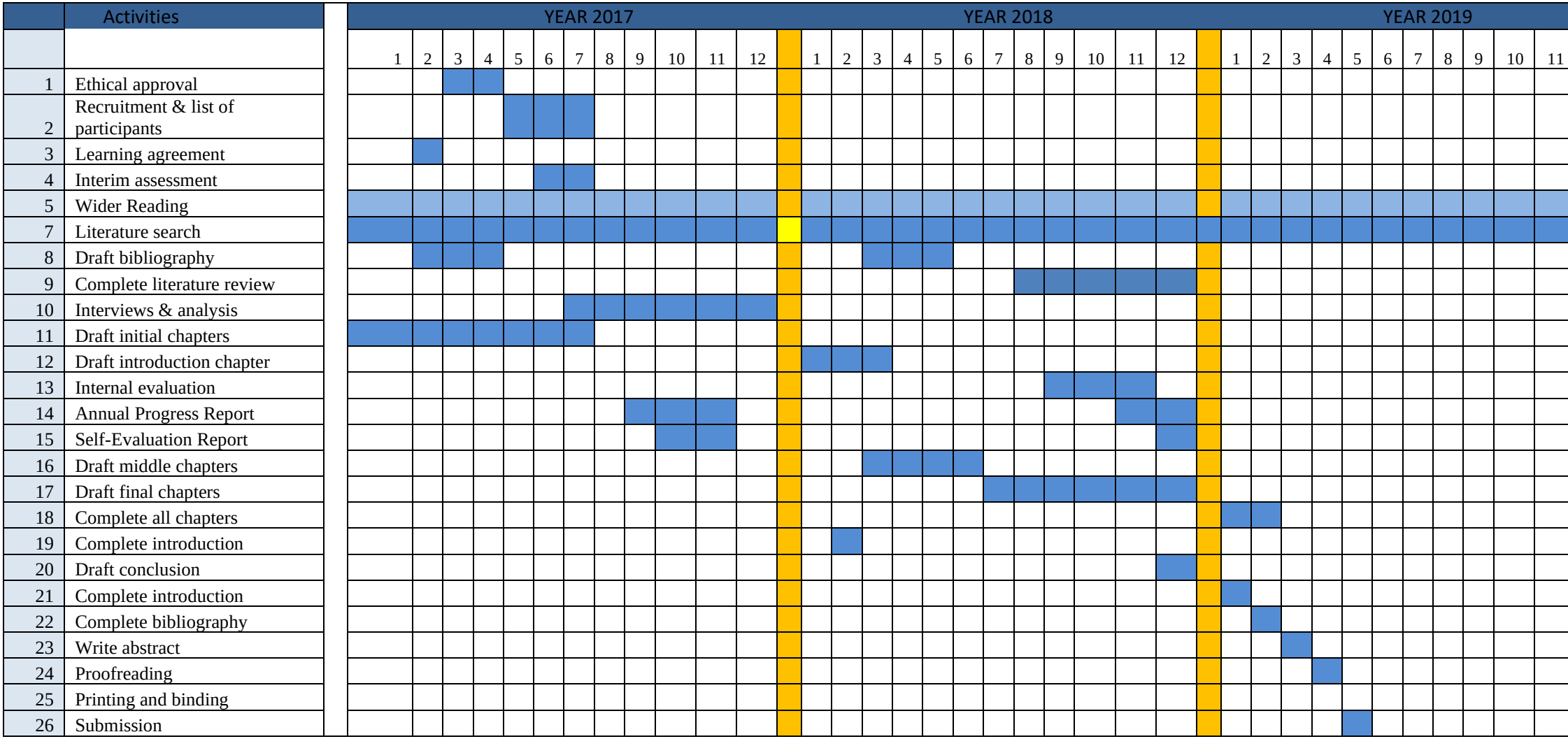
Articles →	**Clark et al 2020**
1. Is there an adequate rationale for using a mixed-methods design to address the research question?	No
2. Are different components of the study effectively integrated to answer the research question?	Yes
3. Are outputs of the integration of qualitative and quantitative components adequately interpreted?	Yes
4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	Partial
5. Do different components of the study adhere to the quality criteria of each tradition of the methods involved?	Partial
MMAT: http://mixedmethodsappraisaltoolpublic.pbworks.com/w/file/fetch/127916259/MMAT_2018_criteria-manual_2018-08-01_ENG.pdf	
Qualitative	
1. Is the qualitative approach appropriate to answer the research question?	Yes
2. Are the qualitative data collection methods adequate to address the research question?	Yes
3. Are the findings adequately derived from the data?	Yes
4. Is the interpretation of results sufficiently substantiated by data?	Yes
5. Is there coherence between qualitative data sources, collection, analysis, and interpretation?	Yes
Quantitative	
1. Is the sampling strategy relevant to address the research question?	Yes
2. Is the sample representative of the target population?	Yes
3. Are the measurements appropriate?	Partial
4. Is the risk of non-response bias low?	No
5. Is the statistical analysis appropriate to answer the research question?	Partial
Quality Score (out of 30)	**22**

Qualitative

Articles →	**Lohrmann et al., 2012**	**Lohrmann et al., 2008**	**Perez et al., 2012**	**Woolls et al., 2012**	**Andreou etal.,2014**	**Bambara et al., 2001**	**Bambara et al., 2009**	**Houchins et al., 2005**	**Inchley-Mort et al., 2014**	**Karger et al., 2018**
1. Was there a clear aim?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2. Study design evident and appropriate?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3. Was design appropriate to address aims?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
4. Connection to a theoretical framework/wider body of knowledge?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
5. Sampling strategy described, relevant, and justified?	Yes	Yes	Yes	No	Partial	Yes	Partial	Partial	Partial	No
6. Data collection methods clearly described and systematic?	Yes	Yes	Yes	Partial	Partial	Yes	Yes	Partial	Partial	Partial
7. Data analysis clearly described and systematic?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Partial
8. Use of verification procedure(s) to establish credibility?	Partial	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Partial
9. Conclusions supported by the results?	Yes	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes

10. Reflexivity of the account?	No	No	No	No	Yes	No	No	No	No	No
Quality Score (out of 20)	**11**	**18**	**18**	**13**	**18**	**18**	**17**	**16**	**16**	**13**

Appendix 4. Gantt Charts (A & B)



Gantt Chart 4A – Anticipated timeframe.

	Activities		YEAR 2020													YEAR 2021													YEAR 2022										
			1	2	3	4	5	6	7	8	9	10	11	12		1	2	3	4	5	6	7	8	9	10	11	12		1	2	3	4	5	6	7	8	9	10	11
1	Recruitment & list of participants																																						
2	Reading																																						
3	Literature search and review																																						
4																																						
5	Interviews & analysis																																						
6	Review Chapter 1																																						
7	Review Chapter 2																																						
8	Review Chapter 3																																						
9	Review Chapter 4																																						
10	Review Chapter 5																																						
11	Review Chapter 6																																						
12	Review Chapter 7																																						
13	Complete review of all chapters																																						
14	Independent review of thesis																																						
15	Proofreading																																						
16	Submission																																						

Gantt Chart 4B – Actual timeframe.

Appendix 5: Interview schedule

Semi-structured interview schedule **(Version 2, December 2020)**

Thank you for volunteering to take part in this study. Do you have any questions that you wish to ask from the PIS? I would like to advise and reassure you that the questions that I will ask you are not a judgement or assessment of you in relation to PBS.

The interview should not last longer than one hour but if you wish to have a break during that time do let me know. Same if you wish to terminate the interview.

Demographic details:

- Job title
- Length of employment
- Experience working with the trust
- Experience of working in challenging environment
-

1. ***Questions***: Tell me about your experience of PBS.

   Prompts:
   - Why are you or have you worked with this framework?
   - What previous interventions have you used?
   - How has the use of PBS changed practice or outcome?

2. In what context/situation have you practised PBS?
3. Can you give me an example of when you applied PBS and what was the outcome of this intervention? (effectiveness)
   - What prompted the need to apply PBS? (essence of PBS). (*Probe added after second interview*)
4. What is your experience of PBS where it was applied?
5. Based on your experience, what were the benefits of using PBS? (ask if 4 is incomplete)
6. What are the difficulties that you have experienced in the implementation of PBS? How did you overcome these? (to ask if 4 or 5 incomplete)
7. From your experience, are there any barriers to the effective implementation of PBS? (ask if 6 is incomplete.) How did you overcome these barriers if any? (*Probe added after second interview*)
8. What are nurses' (including yours) role and responsibilities in areas where PBS is implemented? (leadership, practice leadership)
9. What training do you have, if any, in using PBS? (training needs analysis)
10. How additional training would have helped? Do you feel any form of training is important? (ask if 9 is incomplete)
11. Do you feel PBS is any different from other forms of interventions such as applied behaviour analysis or behaviour modification approach? (other evidence base)
12. Did you and/or your team have the support to effectively implement PBS? (collaboration and partnership)
13. What are your general views of PBS in care settings? (opportunity for participants' comments)

Appendix 6: Reflective Diary

Extracts of my reflective diary for RMN 9.

04.1.21. Today I was excited to talk to about her experience of PBS. I was fully aware that she has worked with me before and I really wanted her to feel comfortable to be able to speak openly about her lived experience…

My first thought was that, although PBS was welcomed and found useful in area of practice, there was a genuine need for further support in the form of training. She is adamant that a hierarchy within the organisation influences who gets the training and who does not. I started to think that Covid-19 has shown some of the real challenges on the wards.

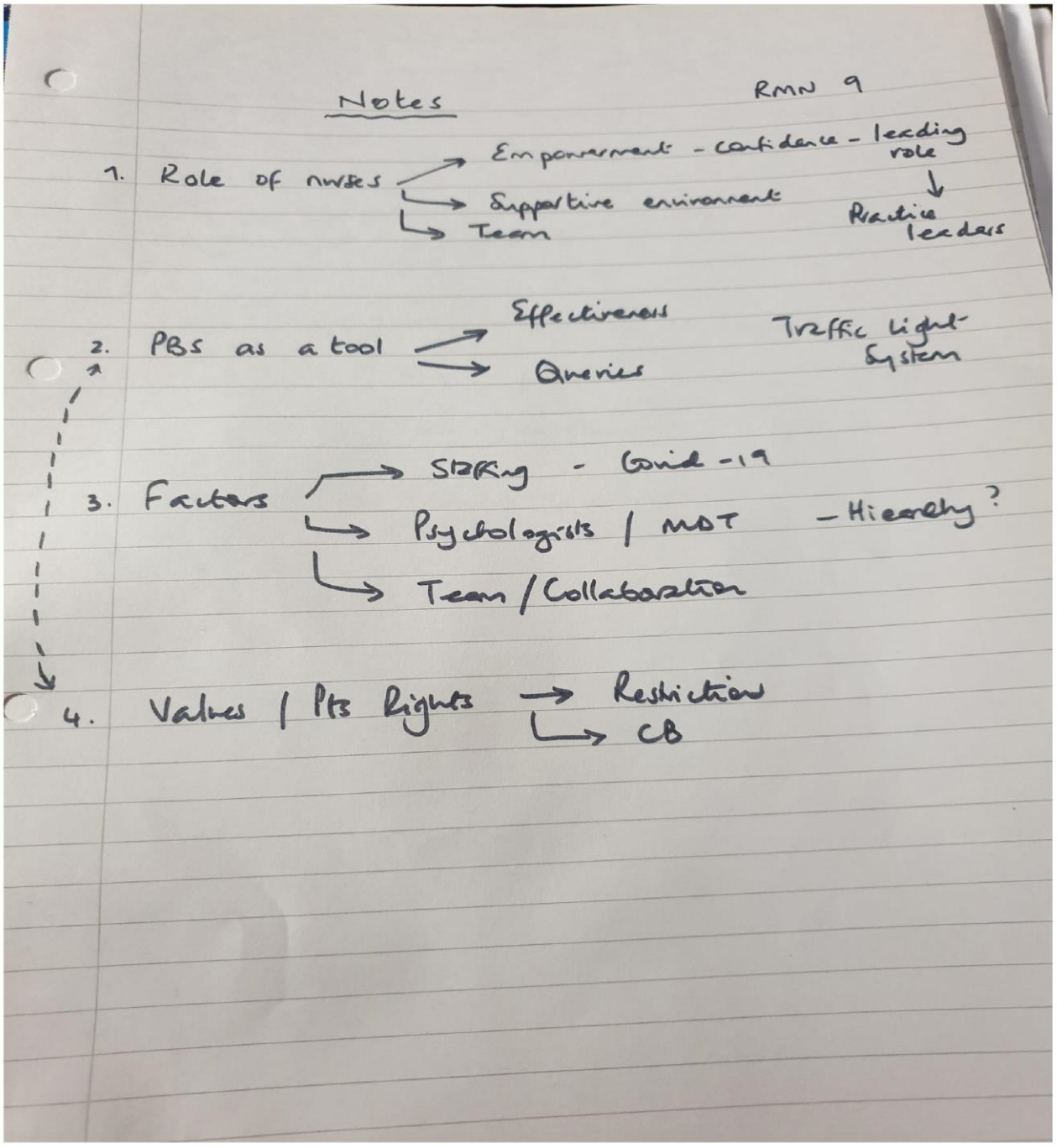
05.1.21. Reading through the transcripts again today, I am aware that my interpretation of the transcripts needed more depth and therefore I will require more time to read and re-read the transcripts. This is what I plan to do tonight.

I do not agree that a traffic light system in place on the wards is the answer to some of the issues that the ward and staff faced i.e. behaviours that challenge. I also do not agree that PBS is, in any way, a behaviour modification framework. It is otherwise no different from ABA – but I can see why some nurses may see it that way. Although, I don't think she wanted to create any similarity between PBS and ABA because she talks about people's rights, ethics, and punitive approaches. I think what is happening here is that PBS is seen as a framework that can help reduce restrictive interventions by using simple and ethical practices.

Note for myself: to review Clark et al. (2020) regarding what it says about nurses asking a few questions such as why it needs to be implemented in a certain way.

I felt good about this interview today as I think that she was comfortable talking about her PBS experience. I felt assertive and confident asking her about her experience working with individuals who self-harm and whether PBS helped. I believed that this question was important because what X was saying from her experience of PBS was a good argument that needed to be explored further in relation to supportive environment. It was clear in what she was saying and at no point I wanted to assume. X

Appendix 7: Additional Notes



Appendix 8: Participant Information Sheet

Title of study: A Phenomenological Exploration of Nurses' Experience of Using Positive Behaviour Support

Name of Researcher: Darren Savarimuthu
[Anonymise for initial approval]

Invitation paragraph
I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Ask questions if anything you read is not clear or would like more information. Take time to decide whether or not to take part.

What is the purpose of the study?
The purpose of this research is to explore nurses' experiences, views, insights, perceptions and attitude of using Positive Behaviour Support in healthcare settings. PBS is a practice that is considered as least restrictive.
By doing a research on this particular subject I intend to involve nurses in the discourse and to contribute towards the development of PBS for future practice

Why have I been invited to take part?
I have approached you to participate based on your experience in mental health and/or learning disabilities services and your familiarity of using PBS in practice. Participants will be invited to participate in the research from areas where PBS has been used.

Do I have to take part?
It is up to you to decide. I will encourage you to read this information sheet. I will then ask you to sign a consent form to show you agreed to take part. You are free to withdraw at any time, without giving a reason.

It is important to emphasise that will be free to withdraw from the study at any time even after you have signed a consent form. You do not have to provide any reason for your withdrawal and there are no implications of you leaving the process.

What will happen to me if I take part?
If you decide to take part in the research, you will be invited to attend an interview with myself and this will be scheduled at a time and location that is convenient to you.

The interview is not expected to be more than one hour long and I anticipate meeting you only once. However, in the event that I would need to clarify anything after our meeting I

will make contact with you. This could be done over the phone or during a very short face-to-face discussion.

During the interview no information relating to your identity will be collected, published or shared with anybody. You will be assigned a code only known to me. The interview will be digitally recorded. These recordings will be encrypted and stored securely in password protected computer. Any information about you will be stored in the same password protected computer, which I am responsible for. Your discussion is shared with others, but this is done anonymously. The only people who may want to see the transcripts are my academic supervisors but, again, your identity will not be revealed.

Your details, content of discussions and anything that you disclose will not be published in a way that identifies you.

Expenses and payments?

Unfortunately, I will not be providing any reimbursements or travel expenses for your contribution to this study

What are the possible disadvantages and risks of taking part?

There are no known disadvantages of taking part in this research study as your contribution is purely discursive in nature. However, I am mindful that some participants may talk about their negative experiences or situations that may cause distress. In order to support you, if needed, professionals from the NHS trust are available to provide independent help. There is also a confidential and free telephone number that participants will be given if they wish to speak to someone outside the trust.

What are the possible benefits of taking part?

We cannot promise that this study will directly help you but the information and your contribution we get from this study will help better understand nurses' experiences of using PBS in a care environment. The data that emerges will contribute to the existing evidence on PBS and this can shape the future application of this practice.

What if there is a problem?

If you have any concerns about this research you can either contact me on 0208 702 4478 or email D.Savarimuthu@edu.salford.ac.uk, or my supervisors below:

Dr Shelly Allen
Senior Lecturer Mental Health Nursing
School of Nursing, Midwifery, Social Work and Social Sciences
3 27, Mary Seacole Building, University of Salford
M5 4WT
Tel: 0161 295 7128

Email: s.l.allen@salford.ac.uk

Dr Julie Lawrence
Lecturer in Social Work, Programme Leader, MSc Applied Social Work Practice (CPD)
Floor 6, Room C604
Allerton Building University of Salford
Manchester
M6 6PU
+44(0) 0161 295 6983
Email: j.lawrence@salford.ac.uk

However, if you remain dissatisfied you can contact:
Dr Susan McAndrew
Chair of the Health Research Ethics Panel
Room MS1.91
Mary Seacole Building
Frederick Road Campus
University of Salford
Salford
M6 6PU
Tel: 0161 295 2778
E: s.mcandrew@salford.ac.uk

Will my taking part in the study be kept confidential?

All information that is collected during the course of the research will be kept strictly confidential. Any data that is published will have no personally identifiable information on it.

As already mentioned above, your participation in this study will remain confidential. No information about you or the content of your discussion will be shared or published in a way that identifies you.

All recordings and interview notes of the discussions will be kept in a locked cabinet which is accessed only by me, including all hard paper/taped data. All records will be processed under the Data Protection Act 1998. The data that is collected will be used to group them into themes and analysed using thematic analysis method.

You will be given a code at the start of the research and you will be identified by this code throughout. There will be one master list with all the names of the participants, that will be held on a password protected computer, and this machine is accessed only by me. All data will be retained for a period of 3 years for the purpose of quality assurance and auditing.

Please note that in the event that you reveal anything related to criminal activity and/or something that is harmful to self or others, I will have to share that information with the appropriate authorities.

What will happen if I don't carry on with the study?

You are entitled to withdraw from the study at any time. You are not required to give any reasons for your withdrawal and there are no implications for withdrawing. You can withdraw from the study within 4 weeks of being interviewed.

If you withdraw from the study I will destroy all your identifiable tape-recorded interviews.

What will happen to the results of the research study?

Once I have collected the data and analysed it, I will write my thesis which is part of my doctoral programme. The findings of the research will be shared with you either over the telephone or during a face-to-face meeting should you wish for this option. I will summarise the findings for the participants and you will receive a copy of the summary. As mentioned earlier, your name or any other personal details will not be published anywhere in the reports

Who is organising or sponsoring the research?

This research study is funded by the NHS trust. However, the trust has no financial or any other interest in this research apart from holding an educational interest.

Further information and contact details:

General information about research in health care settings can be found at **Health Research** - Analysis & Improvement - **health**.org.uk. www.**health**.org.uk/**research**

If you have questions, queries or complaints the person to contact is detailed above

If you need to speak to someone for independent advice and who is not involved in this research, then please contact:

[redacted]

Preceptorship/Mentorship Co-ordinator
Barnet, Enfield and Haringey Mental Health Trust
Chase Farm Hospital
Ivy House
Enfield, the Ridgeway, EN2 8JL, Tel: [redacted]

Appendix 9: Ethics Approval Letter

Research, Innovation and Academic

Engagement Ethical Approval Panel

Research Centres Support Team

G0.3 Joule

HouseUniversity of Salford

M5 4WT

T +44(0)161 295 2280

www .salford.ac.uk/

3 August 2017

Dear Darren,

RE: ETHICS APPLICATION–HSR1617-126–'A Phenomenological Exploration of Nurses Experiences of Using Positive Behaviour Support.'

Based on the information you provided I am pleased to inform you that application HSR1617-126 has been approved.

If there are any changes to the project and/or its methodology, then please inform the Panel as soon as possible by contacting Health-ResearchEthics@salford.ac.uk

Yours sincerely,

Sue McAndrew
Chair of the Research Ethics Panel

Appendix 10: Consent Form

Title of Project: **A Phenomenological explorations of Nurses experiences of Using Positive Behaviour Support**

RGEC Ref No:

Name of Researcher: Darren Savarimuthu

(Delete as appropriate)

➢ I confirm that I have read and understood the information sheet for the above study and what my contribution will be.	**Yes**	**No**
➢ I have been given the opportunity to ask questions (face-to-face, via telephone and e-mail)	**Yes**	**No**

➢ I agree to take part in the interview	**Yes**	**No**	**NA**
➢ I agree to the interview being tape recorded	**Yes**	**No**	**NA**
➢ I agree to digital images being taken during the research exercises	**Yes**	**No**	**NA**

➢ I understand that my participation is voluntary and that I can withdraw from the research at any time **without giving any reason**	**Yes**	**No**
➢ **I agree to take part in the above study**	**Yes**	**No**

Name of participant ……

Signature ……

Date ……

Name of researcher taking consent ……

Researcher's email address ……

Appendix 11: Trust-wide communication

From: COMMUNICATIONS ([redacted])
To: [redacted]
Subject: Nurses' experience of PBS - Research

Dear Colleagues,

Re: Email from Darren Savarimuthu

I am undertaking a research on PBS and this will involve interviewing registered nurses on an individual basis about their experience of the PBS framework. This study is being supported by the Trust and is registered with the R&D department. I have attached a Participant Information Sheet (PIS) for additional details. However, please feel free to come back with questions or queries.

I am recruiting registered nurses and the attached document provides details of who would be considered the most appropriate colleagues who can take part.

I would be grateful if you can support this study by acting as a gatekeeper, handing the documents to potential candidates and ask them to make direct contact with me to further discuss.

Regards
Darren

Appendix 12: Suitability form

	Screening questions	Yes	No
1	Are you a NMC registered nurse?		
2	Have you work with and trained in PBS?		
3	Do you agree to be interviewed as part of the research?		
4	Are you employed by the trust either PT or FT?		
5	Do you agree for this interview to be recorded?		
	Note: This form is to help with identifying of participants in line with the inclusion/exclusion criteria. Name…….. Are you male/female? Contact details……. Date……		

Appendix 13: Letter of Invitation

(name)
(address)

Dear (*name*),

Re: Research Study into Nurse's Experiences of Using Positive Behaviour Support

I am writing to you to invite you to take part in the above research study, which I will shortly be undertaking in the trust. This is a student study and forms part of a professional doctorate in health and social care at the University of Salford.

As a member of both a service and a team that employs positive behaviour support your experiences, views, and thoughts about it as a therapeutic intervention are crucial to the success of this study. If you agree to take part in the study your involvement will assist in the development of an understanding of the impact positive behaviour support has on the quality of care provided to our service users.

To assist you in making your decision I have included an information sheet that provides a detailed explanation of the study and what would be expected of you if you agree to participate. If you feel you could contribute to this study, I have also included a consent form, which you will have signed if you agree to take part.

If you have any questions, please do not hesitate to contact me or my supervisors whose contact details are included on the information sheet.

Thank you.

Yours sincerely,

Darren Savarimuthu

Student, Professional Doctorate in Health and Social Care, University of Salford

Appendix 14: List of Participants' Transcript Extracts

Participants	First construct	Second construct	Sub themes	Themes
RNLD 10	*'In house ongoing session and away days would not make a person an expert in PBS. However, what it does is it creates a level of awareness that you could safely use the model with patient.'*	Nurses do not necessarily want to know everything about PBS. The basic principles of the framework would be enough knowledge for them to feel comfortable and confident with its application.	Confidence	Training
	'My training as a learning disability nurse gives me the skill to understand behaviour and where the patient is coming from by displaying a particular behaviour and also what evidence-based practice that would be most appropriate in a given situation.'		Authority to lead	
RMN 1	*'It is the lack of training, because people are not well trained, this is how we implement the framework, this is how we should follow this to support particular clients.'*	A practical knowledge of PBS and its implementation with service users' involvement are considered fundamental.	Confidence	
	'I worked on a learning disabilities ward and I can remember, I think it was three or four years ago, we had someone who came from external, a speaker who came to talk to us about PBS; she told us about PBS, what the intervention was about.'	A background knowledge of PBS was found useful and sometimes this is all that is needed to initiate some curiosity for someone to find out more about it.	Authority to lead	
RNLD 6	*'It would not really matter whether the training is in-house or external as long as it is extensive and practical. A training that is enough to empower nurses to not only understand the process of PBS but also to be able to lead a team to deliver it.'*	PBS awareness does not have to be sophisticated or achieved through a complex teaching process. A working knowledge can be the start of the development of a leadership position in PBS.	Confidence	
	'I think it's the way things are structured. If you empowered people and said, 'we need you to take a lead on this', then this empowerment helps nurses to bring about the confidence. There are also the MDT effects; nurses do not want to cross the boundaries. It is not a case that you do not know what to do; it is more about leaving it to the ones who is supposed to be doing it.' (confidence)	A nurse, as any professional, needs the education, awareness, and the opportunity to be empowered. Respectful of boundaries and hierarchy, nurses often leave PBS to others especially if they feel lacking in competence or skills.	Authority to lead	

	'I think it's the way things are structured. If you empowered people and said, 'we need you to take a lead on this', then this empowerment helps nurses to bring about the confidence. There are also the MDT effects; nurses do not want to cross the boundaries. It is not a case that you do not know what to do; it is more about leaving it to the ones who is supposed to be doing it.' (authority to lead)	A lack of education or training may make nurses feel as though requiring validation from others.		
RMN 9	*'Nurses were quite involved in bringing ideas together, but it would have been much better if all of us had some formal training on PBS.*' *'I think it was going by what has been said rather than we doing this because of, like, giving us more in-depth knowledge in the sense of why and what PBS is.'* *'Why we are doing it and what is the difference…'* *'This situation would put nurses at the level where there would be no argument because everybody would be at the same level with regard to knowledge, competence and skills.'* *'There's also the idea of mentoring and supervision, whereby junior nurses could be supervised using PBS in practice.*' (confidence)	Nurses can contribute towards PBS implementation and identify equal access to structured training as essential. First-hand information and knowledge from reliable source that depicts PBS as a practical and scientific framework is much welcomed. It is not enough to just satisfy curiosity about what PBS is. Nurses need more knowledge so their practice is informed. PBS training opportunities can potentially help nurses in an MDT context where everybody shares knowledge and competence equally. A supportive process or system can be helpful in coaching/mentoring those in needs towards their professional/personal development in PBS.	Confidence Authority to lead	
RNLD 12	*'Because, as you know, repetition is important for staff to remember. It also helps to remove some of the bad practice, mistake, but more importantly people wouldn't forget about it.'* *'We definitely need to make nurses become more competent with more training. And also, to be able to trust in their abilities and their knowledge.'* (authority to lead)	On-going reflective practice in the field of PBS is useful towards the integrity of the framework and towards staff upskilling. Nurses have the potential and are in a good position to take different roles in the field of PBS. They need opportunities and for others to believe in their capability/capacity to further develop.	Confidence Authority to lead	

RNLD 5	*'It was in my second year while at university as a student nurse. We attend this conference every year where there is somebody who talks about PBS for everybody to be aware of how it [PBS] can be used to support clients more effectively. So that is when I heard about it and then after that I never heard of PBS, even during my placements.'* *'I think it is part of their (clinical psychologists) training, education. I think they have more knowledge on this than nurses. If we could also train nurses, then that would be useful. Psychologists are also very willing to learn and develop strategies. Nurses are somewhat reluctant to do so. This could be because of lack of opportunities, lack of confidence or just a lack of interest.'* (Confidence)	A systematic exposure and approach to PBS awareness is required at various levels from pre-registration level throughout post registration. Belief and perception that different disciplines have different attitudes towards professional development in particular with PBS. Several factors are at play that often result in a lack of interest from nurses.	Authority Confidence to lead	
RNLD 11	*'The more you train staff the more up-to-date they are with the model and they can relate with the practical aspect of it. You can never have enough training because there are always changes.'*	The nurse wants PBS training that is effective and meaningful/useful in their day to day clinical implementation of the framework.	Confidence Authority to lead	
RMN 2	*'On the LD ward where I was moved to, PBS was one of the main interventions. There was a lot of engagement with PBS and professionals were very motivated and I became more aware of the practice and its features.'* *'Having worked on X ward for a number of years and also having a psychology background has helped me understand PBS concept and how effective it is.'* *'PBS as an intervention requires some sort of awareness and nurses perhaps did not have it. Or they do not get it. This is why nurses were limited to only ensuring the intervention was offered to service users.'* (confidence) *'Nurses perhaps were not asked to lead; but it is also about how much nurses know about PBS. Nurses are often seen as the ones to put in actions any intervention or care plans rather than facilitating.'* (authority to lead)	Knowledge of PBS can enhance MDT working, attitude and confidence. This in in the best interest of service users. Staff have relied on previous background/experience to fully appreciate PBS and this has helped towards their interest. The nurse finds a number of limitations when it comes to their input with regard to PBS. It seems that nurses need a consensus or process whereby a decision is made in relation to PBS. Nurses are not seen as able to lead.	Confidence Authority to lead	

RMN 3	*'During my university training I became aware of PBS. We were given a hand-out and then we went through the slides for half an hour/45 minutes. Then when I started working as a nurse, I came across PBS again. However, there was nobody as such to give us a lecture. Eventually psychologists were delivering brief basic sessions on PBS. Psychologists were the one who were more involved with PBS.'* *'There is a lack of interest; a lack of confidence and training. Nurses are too comfortable in their roles. It goes back to how nurses are trained in the first place. How different our training is to that of psychologists and OTs. We need to review our formation to start with. Not all psychologists are experts in PBS, but they seem to have developed an interest in the framework.'* (confidence)	There is a gap between university and organisational input. No continuity evident re PBS awareness. Psychologists have identified a gap in leadership. Querying different professional training. Nurses' education pre and post registration may not be enough, and update should be timely. Raises question about supervision, practice leadership and support re PBS.	Confidence Authority to lead	
RMN 8	*'This ensured that staff had awareness of the model and that PBS was being used in an informed way.'* (confidence) *'This was a learning disability ward and I think they were very much advanced in PBS compared to my ward. The nurses have had exposure and preparation to use the framework.'* (authority to lead)	Sense of determination to use PBS as it should be rather than being a tokenistic process or exercise	Confidence Authority to lead	
RMN 14	*'Staff may see PBS plan as a piece of useless paper only because they are not aware of the scientific evidence underpinning it.'* (confidence) *'I think knowledge brings the confidence and we need both.'*(confidence)	Nurses may risk seeing PBS as yet another tool to use without the required preparation or know how.	Confidence Authority to lead	
RMN 16	*'I suppose I was one of those people that were saying yeah, yeah, yeah. When in fact I had no clue.'* (confidence) *'It is useful to try and see how a PBS plan can be developed and how you can support a person who has complex needs and challenges.'*(confidence)	There was a feeling of going along, which could have been unethical. Practical understanding of PBS is crucial in supporting service users.	Confidence	

	'…because in our nurse training I didn't have anything that was ased around PBS and there were limitations around this.' authority to lead)	The ability to lead PBS would have been reinforced if this was taught at pre-reg. nursing education level.	Authority to lead	
RMN 17	*'PBS training mandatory but having a yearly update at least would help staff and patients.'* (confidence)	The longevity and success of PBS depends on staff exposure to the framework.	Confidence Authority to lead	
RMN 18	*'…but having that course to do, I think just helps you feel as if like you know what you are doing.'* (confidence)	A systematic approach to PBS may provide a sustainable framework of care that is acceptable and embraced.	Confidence Authority to lead	
RMN 4	*'It would be good to have the confidence I should say to be able to implement PBS. It is not about the psychologist to come and tell us about PBS.'* (authority to lead)	Tension may affect the delivery of evidence-based practice. No discipline should have any priority to lead but this practice should be implemented jointly with nurses holding an equally important role.	Confidence Authority to lead	
RMN 9	*'So, I am not giving excuses, but these are the reality of the current situation and to be honest even without the Covid-19 pandemic we already had issues around resources – specially registered nurses – and this wasn't only a local issue but a nationwide problem.'*	Various factors are at play in the delivery of PBS, one of which is having the staff who are accountable and ready to make a difference.		Resources
	'And I would want to see everybody contributing to the model rather than having one discipline leading its implementation.' (teamworking)	A concerted effort re PBS is welcomed. This gives nurses the status that they deserve thanks to their relationship with service users and others.	Teamworking	
	'Also making sure that nurses are working in collaboration with everybody else, including psychologists and medical doctors, so that there is a full MDT approach to the implementation of the framework.' (teamworking)	There is appreciation and recognition that nurses and others need to work as a team in the delivery of PBS and no one discipline can achieve this on their own.		
	'It could also consist of a mini diary that reflects what needs to be done the type of thing that people would want to do.' (consistency)	There is the idea of reflective practice and the use of a reflective journal/diary that would help nurses to improve PBS practice.		
	'So, to a certain degree it works but the difficulty that we had was consistency or a lot of consistency because staff were not following the plan.'(consistency)	A clear and systematic approach was lacking in the delivery of PBS as staff were not working together but instead in silos.	Consistency	

RMN 4	*'We need more than just a good PBS plan; we need staff to believe in the framework. We want attitude to change so that PBS can be fully implemented. What we also need is everybody working together with the service users and not just a couple of individuals coming up with a plan without wider consultation.'* (teamworking)	The engagement from expert by experience is described as a key principle of PBS whereby service users fully contribute in the decision-making process. Service users should be part of the team. Emphasises the importance of working collaboratively, not only with different professions, but a partnership that involves service users co-productively. Expresses view that it is fundamental to engage nurses in the consultation process during the formulation of PBS plans.	Teamworking Consistency	
RMN 1	*'The MDT agrees to a plan of how we support service users with challenging behaviours so then PBS works well.'* (teamworking) *'When it comes to team discussions, not everyone in the team necessarily agree and come to the same agreement on PBS. It's about following what is in the plan, each and every staff doing the same thing.'* (teamworking) *'The other thing is a lack of staffing that compromises the delivery of PBS.'* (teamworking) *'This was agreed by the MDT, but I was not part of the decision-making. Nurses' role regarding PBS was to feedback to the team on the presentation of the service user following PBS. The feedback goes to the psychologist during ward rounds.'* (teamworking) *'Inconsistency comes due to a lack of training; because people are not well trained, not been told how to implement the framework; not shown how to follow PBS plans with particular clients. The other thing I can say is there is a shortage of nursing staff.'*(consistency)	The importance of a collective approach in PBS is strongly advocated- whereby there is a collective responsibility and accountability. It is more acceptable that disagreements are heard by a team and when a decision is made, the PBS plans are accepted, and service users are supported in its implementation compared to when these disagreements are not considered at all. The staffing issues raised here do not only fit with the shortage of nursing staff in the NHS but go beyond that. A team requires staff with the attitude and skills to be able to work together. The nurse felt left behind despite having the required experience in PBS whereby they could have contributed a lot. This could be an issue of competence not being recognised hence affecting team spirit. Nurses understand the importance of consistency in care delivery. However, without a team that learn and share together, collaborative work can be compromised.	Teamworking Consistency	
RNLD 7	*'The psychologist has developed good rapport with the team so most colleagues would go to them for advice regarding PBS.'* (teamworking)	RNLD 7 stated that clinical psychologists have developed a rapport with nurses so there is a reinforced teamworking atmosphere is some clinical areas.	Teamworking	

	'In summary the PBS plan is written in a way that it can be picked up by anybody in the care of the service user and follow it up.' (consistency)	Psychologists are portrayed as important team members regarding PBS. The nurse identifies other disciplines as more competent in PBS practice. The formulation of the PBS plans is essential to ensure continuity of care and most importantly the service users can relate to the plan. The nurse accepts that a succinct and explicit plan helps facilitate a consistent approach to care delivery regarding PBS.	Consistency	
RMN 8	*'The way it worked was that the clinical psychologist would get feedback from MDT and would go away to develop a PBS plan.'* (teamworking)	Reference is made to how clinical psychologists work in certain areas where the development of a PBS plan is by one discipline; and a trusting professional relationship between members of the team where there is respect and each member is valued. A lack of consultation and detailed discussion with nurses forming part of a team may affect the validity of the PBS plan but also affects the holistic approach of the intervention.	Teamworking Consistency	
RNLD 11	*'There was an element of trust in that kind of approach but there's also the issue of working together in collaboration and not an attitude of me knowing more than you, kind of thing.'* (teamworking) *'I think we have been quite lucky in the sense of the psychologist understood that nurses were the one who have a better rapport with the service users, and that nurses would be the ones who would ensure the implementation of this model.'* (consistency)	Argues that psychologists agree that nurses are best placed to ensure PBS is being implemented, mainly because of nurses' relationship with patients on the wards. The nurse finds knowledge and experience of every member to be useful and important in the formulation of a PBS plan. Every discipline has to feel involved and heard, while service users are at the centre. The nurse feels that the psychologist has realised that nurses are important in the sustainability of PBS and that service users would embrace the intervention if nurses are to be central to it.	Teamworking Consistency	

RNLD 5	*'So, what I would do is make sure the team is communicating well, delegate properly, i.e. support workers, key workers, monthly meetings, fortnightly meetings, to then discuss how is it working, what do we need to do, delegating to other staff and engage in team effort.'* (teamworking) *'Not everyone in a team comes to the same agreement on the issue of PBS. It is about following what is in a PBS plan; every staff doing the same thing. When a team is split in the way they see PBS there is inconsistency. This is also because of a lack of training and awareness. Staff employs PBS the way they feel like it.'*(consistency) *'My colleague who devised PBS plans said staff do not follow the plan. Day staff doing one thing, night staff doing something different, there is a lack of consistency. They forget about PBS; it is in a folder on a shelf, nobody is referring to it, nobody is using it.'* (consistency)	Alludes to challenges that staff face in relation to PBS. One such difficulty concerned an inconsistent approach to PBS plans due to staff often misunderstanding the framework. When asked how she would improve teamworking, RNLD 5 indicated that it was not only important, but a fundamental requirement for PBS to succeed, as the framework is composed of multiple elements requiring different expertise. PBS performance at an individual and ward level requires practice leaders to ensure fidelity to the intervention. The difference in views is a good thing in PBS as it shows professional disagreements being listened to. However, a difference in opinions should always benefit the service user while also reinforcing teamworking. Disparity in the delivery of PBS is evident due to a lack of a concerted approach that is communicated to all through joint working.	Teamworking Consistency	
RNLD 12	*'Qualified nurses were, but the other healthcare assistance were not, necessarily aware or PBS.'*(teamworking) *'Sometimes you may have the qualification, but you can always forget, and you also learn from everybody within the team.'* (teamworking)	Argues for better collaboration between all colleagues, including healthcare assistants, and for a process whereby everybody, irrespective of grade or status, receives appropriate PBS training. Teamworking in relation to PBS was seen as a way of learning from each other irrespective of status.	Teamworking Consistency	
RMN 2	*'Working with the same set of objectives is quite important for PBS to be successful. Everybody should be liaising with each other and be united.'* (teamworking)	Referred to teamworking as primarily about working together to achieve common purposes, but also about staff connecting with each other. This was described as fundamental to the success of PBS.	Teamworking Consistency	

RMN 15	*'We had a supportive team, so we have been able to come together with PBS and make it work.'* (teamworking) *'Maybe we could not have got this done without the help of the OT.'* (teamworking)	Innovative methods to keep staff and service users informed and enthused about PBS is important with common goals. There is a genuine recognition of others' input in the delivery of PBS. OT's contribution is not being compared with that of psychologists, but OTs are offering practical expertise.	Teamworking Consistency	
RMN 16	*'…but to get different disciplines to work together as well, so that the approach is not disjointed.'* (teamworking)	PBS implementation requires a co-ordinated approach where different disciplines come together leaving egos, hierarchy and status aside.	Teamworking Consistency	
RNLD 6	*'We need consistency, continuity and effort from each and everybody within a team for the intervention (PBS) to work.'* (consistency)	Talked about the consequences of inconsistencies, the significance of continuity in care and team effort. PBS was therefore deemed to be a framework that necessitates stability within a team and a collaborative ethos for it to produce the desired effects.	Teamworking Consistency	
RMN 14	*'…remind staff that once they are on shift, they know what works for which patient and that things need to be done.'(*consistency) *'I think having permanent staff working with our patients is also important and not relying on agency staff' (consistency)*	A positive handover between colleagues where PBS is central to the delivery of care should be part of the fabric of the organisation. PBS depends on staff who are committed, skilled and have the best interest of patients at heart.	Teamworking Consistency	
RMN 17	*'Because we actually have all of our patients on a PBS plan, so we have regular monthly PBS discussion.'* (consistency)	The success of PBS is by adopting an individualised approach and ensuring that everybody has a plan in place that is evaluated as an important part of the whole process.	Teamworking Consistency	
RNLD 10	*'But on the ward where I am at the moment there is ongoing training provided by clinical psychologist.'* (seen as experts) *'The people who create the PBS plan do not necessarily know more than what nurses do.'* (barriers) *'Currently, PBS plan is designed by people who are not even on the ward and these people are clinical psychologists or speech and language therapists. Nurses do not have a lot of input in the*	The role of clinical psychologists is essential in the delivery of in-house PBS support and training. The creation of a PBS plan should not be a one-person task. Nurses are good at establishing good rapport with service users, so, their input cannot be disregarded.	Barriers Seen as experts	Psychology led practice

	design of PBS. Nurses become the staff group who…show the delivery of the plan when I think this needs to be looked at. We cannot have a situation where nurses need to obey because we can do a little more than that.' (seen as experts)	Clinical psychologists spend less time with patients compared to nurses. However, they still have a leading role regarding PBS. Nurses have the potential to do more in PBS, but this is not the case at the moment. Nurses want to do more than just being subservient.		
RMN 4	*'[Clinical] psychologists are the leads; they develop the plans and they pass them on to the team. They are the ones who decide what to include in PBS plans.' (seen as experts)* *'Psychologists are very willing to learn and develop strategies. Nurses are somewhat reluctant to do so. This could be because of lack of opportunities, lack of confidence or just a lack of interest'* (seen as experts)	Clinical psychologists were seen as the leading figures in PBS and the experts who had an overall dominance and influence on its design and application. Clinical psychologists are eager to be involved and to learn, hence they are in the forefront of PBS implementation compared to nurses who are described as passive members of an MDT.	Seen as experts Barriers	
RMN 9	*'I think credit to them [clinical psychologists] they have done some research around it and they know a lot more about the model, so they know why they are doing what they are doing and we don't.'* (seen as experts) *'What are you doing to challenge if you do not know how it works and you do not have the knowledge behind you?'* (barriers) *'I think anxiety and fear around the unknown is something that needs to be addressed.'* (barriers)	Is of the view that clinical psychologists have the preparation, education, and have done the research on PBS for them to be PBS practice leaders. A lack of empowerment and confidence from some nurses have contributed towards clinical psychologists taking a leading position in the field of PBS. Psychologists are familiar with PBS and therefore comfortable with the intervention compared to nurses.	Seen as experts Barriers	
RNLD 7	*'I also feel conversations with expert colleagues and working closely with colleagues who are skilled, competent and knowledgeable is as important as formal training.'* (seen as experts) *'It is also useful to have training to be able to understand behaviours as in learning disability population group; mental health and physical health are key to properly understand behaviours.'* (barriers)	Psychologists are respected for their input in PBS. However, other disciplines can take similar roles and become experts in the field. Argues that other barriers to the implementation of PBS could be due to lack of training, such as physical health and mental health within an LD context, and this training cannot be dismissed. It can be argued that clinical psychologists and	Seen as experts Barriers	

		other professionals could facilitate these training so that staff better understand behaviours as a whole.		
RMN 2	*'Psychologists and occupational therapists are the main people taking a lead in PBS, but nurses are very much engaged in the process in ensuring PBS is being delivered.' (seen as experts)* *'Once psychologists have positioned themselves as leaders, and this being acknowledged by senior members of the MDT [psychiatrists] – then nurses find it difficult to become interested in or even taking the role of leader. There is a degree of unwillingness to engage. This is not necessarily being unprofessional but there is a lack of cohesion.'(barriers)*	A coalition between disciplines while disregarding nurses' competence and knowledge of patients' needs regarding PBS is a serious issue. The central role that psychologists have taken has become difficult to infiltrate as they are fully supported by a hierarchal system.	Seen as experts Barriers	
RNLD 12	*'So, technically, the psychologist who are designing the plans rely heavily on the feedback and the narratives from the nurses.'* (seen as experts) *'To be honest, they say 'conflict' sometimes because the person who is 24 hours with someone and then you coming two days in a week.' (seen as experts)* *'You can train someone – I'll provide everything to empower nurses but there is always the personal willingness and commitment that is quite important.' (barriers)*	On one hand nurses are already playing an important role in relation to PBS. However, this input is being done in a secondary manner rather than being in the forefront of the process. Despite spending least amount of time with service users, psychologists are given a favourable position to lead PBS. Nurses may sometimes put themselves in an unhelpful situation whereby one may question their readiness to take on the challenge in learning and adopting new initiative such as PBS.	Seen as experts Barriers	
RNLD 5	*'We don't have to rely just on psychologists; nurses can do this. I could go out and help put a PBS plan [in place] and in actual fact probably we are more suitable to deliver PBS; but we need to have the education.' (seen as experts)*	Felt nurses could lead and deliver PBS, provided they were given adequate training.	Seen as experts Barriers	
RMN 8	*'PBS being a behavioural approach does put psychologists in the right position to lead PBS as they understand behaviour better.'* (seen as experts) *'From my experience in some situations PBS did not work- not because it was a bad plan; it was mainly because many staff did not know what PBS was.'* (barriers)	The training of psychologists underpins their standing in the field of PBS which may somehow validate their role and weight in the application of the intervention. PBS described as not working due to lack of training, and this was seen as a barrier to applying evidence-based practice.	Seen as experts Barriers	

RNLD 11	*'I just assume that they have more knowledge than anybody else on the subject – and that they have the training to make them competent.'* (seen as experts) *'I think it would be harder to implement PBS in the community because it may become quite difficult to track progress, and what you wouldn't want to happen is PBS to become just a piece of paper for the sake of it rather than being a live document as it is on the ward.'* (barriers) *'Training but I have had ongoing discussion with colleagues as a PBS lead. But that was a conversation that I have had with the psychologist ...- that [training] was one of our plans but this never took off especially with everything else that is happening at the moment with regard to COVID-19. But that is something that would need to come back on the agenda once the situation becomes a bit more settled. it has always been at the back burner.'*(barriers)	Barriers such as Covid-19 pandemic, staff commitment and fears were some of the other aspects that were raised by some participants. The perception is that on a ward setting PBS is implemented much better while community services would not cope with that level of engagement. It is rather unfortunate that, as a result of this belief, service users living in the community may not be given an opportunity to work with PBS. Covid-19 has set new challenges that may hinder the development of PBS- and once more there is heavy reliance on psychologists to launch it.	Seen as experts Barriers	
RMN 3	*'Of course, clinical psychologists do a good job but they come to the ward once or twice a week and see the patients for half an hour or 45 minutes and they just go off; and they go and write a PBS plan.'* (seen as experts)	Psychologists were not necessarily the most appropriate colleagues to lead PBS; and this was based on their views that psychologists spent limited time with service users which were insufficient to build therapeutic relationships.	Seen as experts Barriers	
RMN 1	*'I think purely it is the training that psychologists have had. Their education helps them better understand interventions like PBS. Nurses are doers; they will get on with it by helping with the implementation of PBS. In terms of taking a lead in doing behavioural plans it's always the psychologist.'* (seen as experts) *'Patients were not fully involved in the PBS programme. By me saying this, I mean patients may have a meeting with the psychologist without the involvement of a nurse. He may not know what was discussed at handover; but I think it is essential to engage nurses in the process. An absence of nurses may mean a lack of leadership from them.'* (barriers)	Psychologists were perceived to have training that allows them take responsibilities that nurses cannot take. Co-production may not be taking place in the real sense whereby service users work alongside professionals in the design of PBS. Nurses are considered as key players in the process of co-production.	Seen as experts Barriers	

RNLD 6	*'If you look at the current environment, [clinical] psychologists are the ones who lead on matters involving behaviours [of concerns]. Psychiatrists deal with mental health issues and, us nurses, we are the one who follow the instructions, which is unfortunate.'* (seen as experts) *'If we have a situation whereby the psychiatrist suggests nurses should take a lead, then nurses will be more engaged with this. You will find people who would want to be involved. There are a few nurses who are very good at PBS but never had the chance to be involved at that level.'* (barriers)	When it comes to behavioural approaches, it has always been psychologists' areas of expertise, and this was why PBS was left with psychologists to deal with. Senior MDT members such as psychiatrists play an important role in deciding who should lead PBS Nurses may require some form of endorsement from senior figures from the hierarchy to engage and lead PBS.	Seen as experts Barriers	
RMN 14	*'The assumption is that psychologists have the knowledge, skills and competence to manage PBS.'* (seen as experts) *'Nurses and other disciplines seem not be part of the process and most of the time not being aware of what is happening.'* (barriers)	The underpinning argument from nurses is that psychologists are trained in a way that justifies their level of involvement. The experience of a wide range of staff and disciplines do not seem to be taken into account when working with PBS, leading to a lack of awareness or involvement.	Seen as experts Barriers	
RMN 15	*'I know clinical psychologist was involved in the in-house training, so I found it very useful.'* (seen as experts)	Psychologists play a pivotal role in training other disciplines as well as leading the intervention. Therefore, this framework seems to be grounded in the organisational structure.	Seen as experts Barriers	
RMN 16	*'…but I would assume that maybe they have some type of training that relates to the implementation of PBS.'* (seen as experts) *'Psychologists, don't spend as much time with these patients as we (nurses) do, and I think as a nurse…'* (barriers)	There is the acceptance that psychologists, irrespective, of level of training or experience, have knowledge of PBS. This belief and supposition are based on the behavioural underpinning of PBS. A nursing approach and values in PBS is considered fundamental towards co-production and patient engagement which psychologists need to improve on.	Seen as experts Barriers	
RMN 17	*'…this was delivered by the psychologists on the ward and they have taken a lead on the implementation of PBS.' (seen as experts)*	Consistent theme regarding psychologists taking a standpoint in the delivery of PBS. This has created a reliance on psychologists to provide training and directions.	Seen as experts	

	'…we have the service users, and talking to the family and getting everybody on board rather than just being a psychology mainly led.' (barriers)	A successful PBS-driven care is founded on a multi-agency approach where service users should be at the centre of the process, and not relying on the dominance of any discipline.	Barriers	
RNLD 18	*'We did the PBS training and – because the psychologist had done the course, so they were, like, already aware of behaviour and behavioural approach.'* (seen as experts)	Some disciplines have had opportunity to access PBS training while others have not, which may raise issues of equal opportunities in training and development.	Seen as experts Barriers	
RMN 3	*'Let's say service users are not behaving well, then they know they are not getting that reward… that is what I have noticed, and they feel a bit like they have let themselves down… they have to start again to earn that reward.'*(understanding behaviour)	At times PBS is being linked with a reward chart which may help with behaviour modification strategy- however, it may not help to understand the functions of the behaviour.	Understanding behaviour	Restrictive interventions
	'PBS is a model that is different in the sense that it takes into consideration the human value of individuals. We know in the past service users have been ill-treated and there has been abuse and violation of basic human values.' (human rights)	The human value aspect of individuals receiving treatment is of prime importance. The nurses in this study appeared cognisant of past incidents of abuse and they understood the difference that PBS can make.	Human rights	
RMN 9	*'…ward there was a lot of issues and tension around drugs use so staff would often end up involve in physical restraint seclusion and other restrictive intervention.'*	PBS framework and its principles have been successfully used in other areas of needs. There is a clear understanding of how PBS can influence care in general and while doing so has due consideration to patients' safety.	Understanding behaviour	
	'Currently COVID-19 has changed the ward environment so patients are facing a lot more restrictive intervention therefore PBS could have been used to support these service users.'	Patients have a right to be given all the support and care that they need and during the pandemic lockdown and restrictions on the wards PBS could have served some benefits to the patients.		
	'But you just lose interest while you don't know the essence of why you're doing what you're doing.' (understanding behaviour)	The nurse wants to practice an intervention based on the knowledge underpinning it. Nurses remain aware of the importance of evidence-based practice in understanding behaviours		
	'Traffic light system may not be tackling the problem instead it could be a system whereby certain behaviours are deemed acceptable and others are not.' (understanding behaviour)	Like a reward chart, a traffic light system may find its place within PBS but gives the perception that PBS is a behaviour		

	'…and it is supposed to be supporting the individual rather than being punitive or infringing on people's human rights' (human rights)	modification strategy rather than a framework that helps understand patients' needs and improves quality of life. Expresses an understanding that the principle aim of PBS is about respecting human rights of the individuals, albeit those whose behaviours are seen as challenging.	Human rights	
RNLD 7	*'In some cases, PBS has helped service users when going back in in-patients' services where seclusion and restraint could have been the outcomes in some extreme cases.'* *'We have to make necessary adjustments such as pictorial, easy read formats of PBS including plans written in first person in a co-productive way.'* (human rights) *'It helps situations not reaching escalation point and it reduces the need to use PRN medications.'* (human rights)	PBS could have avoided re-admission of patients if it was implemented in the community services. Patients have a right to be provided with care and support to maintain community living. The functional assessment part of PBS is a key element of the process that informs the practitioner and service users of the step by step approach for a successful implementation. Patients are entitled to receive the least restrictive care when in ward settings and this can be achieved through PBS.	Understanding behaviour Human rights	
RNLD 6	*'So, PBS focuses on least restrictive practices as our feeling is that if someone presents as challenging then they are so for a reason. So, it's not about being punitive or taking away any privileges. It is more about working with that person to look at other ways to ask for things or deal with situations.'* (understanding behaviour) *'In similar situations in the past the person would be taken to seclusion or have their leave suspended or something of that kind. We decided we would not go down that road.'* (human rights)	Opportunity to reflect on restrictive interventions within their respective clinical areas and the impact of PBS towards reducing these interventions. The nurses commented that a good understanding of challenging behaviour could change practice and certainly help to reduce restrictive interventions and improve quality of life Another participant explored practices during which service users were placed in seclusion or long-term segregation following incidents. However, in some areas the treatment that service users received was greatly improved and was different from past practices, especially with the advent of PBS.	Understanding behaviour Human rights	
RNLD 11	*'We try to make plans within ourselves in terms of how we come to help the quality of life of patient such as reducing the number of behaviours of concern.'* (understanding behaviour) *'…concerned us, but we have to take into consideration what has happened and how do we prevent that from happening. Like, do*	A holistic approach to quality of life of patients have been improved by enhancing patients' experience of behaviours that challenge. PBS helps understand the patient's recovery journey and other life experiences that may affect their rehabilitation. The intervention supports service users with the	Understanding behaviour	

	you know any signs of relapse and how do you feel like if it's going to come up again?' (understanding behaviour) *'I think sometimes, not necessarily all the time, understanding could be a barrier but I can't think of any other barriers as long as we empower patients to take control of their care and we provide a platform and opportunities for them to be able to do that then there shouldn't be major issues.'* (human rights)	identification of triggers, progress and interventions that are required in a timely manner. Failure to understand and appreciate a person's behaviour could be considered as a lack of duty of care. Most importantly, failure to empower patients to take control of their care through PBS can arguably be a human rights' issue.	 Human rights	
RMN 4	*'Different teams under the same ward can work differently. Some share the views that medications work better than PBS with regard to addressing challenging behaviour.'* (understanding behaviour)	Education on challenging behaviour could help clinicians and other stakeholders to adopt appropriate strategies in supporting individuals who exhibit difficult behaviours. This awareness could contribute towards reducing medications in challenging behaviour.	Understanding behaviour Human rights	
RNLD 5	*'I think with PBS it's about looking at the bigger picture and see how we can as nurses, as support workers get to understand the client and see how our actions, how the environment interacts with that client.'* (understanding behaviour)	A RNLD describes PBS as a tool that could assist staff understand service users' presentation in relation to their environment and relationship with staff.	Understanding behaviour Human rights	
RMN 2	*'PBS has done a lot of good in the field of challenging behaviour. Staff, by using PBS, need to work with service users and other stakeholders to fully appreciate service users' demeanour and explore what will help towards addressing them.'* (understanding behaviour) *'PBS is different from other interventions as it is a dignified approach to challenging behaviour. It helps maintain respect for the individual and takes us away from inappropriate and degrading treatment that service users have endured in the past.'* (human rights)	There were accounts on the attribute of PBS around valuing individuals' uniqueness and their associated presentation that could be achieved through a functional assessment; and to improve the QoL of individuals. Valuing the person is the ultimate essence of PBS which means caring for someone without compromising on the fundamental of patients' rights.	Understanding behaviour Human rights	
RNLD 12	*'When you are doing a PBS plan you tend to accommodate what would change the behaviour of the patients and we are looking at what to accommodate to adapt for him or her – how we can improve.'* (understanding behaviour)	PBS allows for on-going evaluation of care so that the patient's situation always improves.	Understanding behaviour	

	'It's extremely important to involve the service users in the planning and to get their views about anything and everything.' (human rights)	Co-production remains at the core of PBS where patients are in control of their care.	Human rights	
RMN 14	*'…think that it's important that we have a good therapeutic relationship with our patients.'* (understanding behaviour) *'Knowing the past trauma of an individual helps understand the care that the person requires and what re-traumatise the person.'* (understanding behaviour) *'…that if we do things appropriately and as and when necessary we will avoid the person getting to a stage where there is violence.'* (human rights)	It is argued that PBS helps build rapport between patients and staff and therefore this alliance supports a trusting relationship. A trauma informed approach to PBS is the way forward to fully understand lived experience. A timely approach to care with PBS is of essence as it provides patients with all the opportunities to be cared in a safe and therapeutic environment.	Understanding behaviour Human rights	
RMN 15	*'And I think also it ties in with the trauma-informed approach to care that people didn't understand.'* (understanding behaviour)	A trauma-informed PBS model is helpful as it ties an individual's past trauma in with the current experience/behaviour of patients and informs future interventions with PBS being central.	Understanding behaviour Human rights	
RMN 16	*'We have to look at things like the history, the physical health, emotional needs of this person…'* (understanding behaviour)	PBS allows a holistic and functional assessment that supports the individual with regard to behaviours that challenge.	Understanding behaviour Human rights	
RMN 1	*'I mean, supporting service users in areas that are positive for them to have a meaningful day because after all it is a day to day thing, where the person may slip out a bit of the goal. Instead of talking more about the positives, we revert back to use punitive and restrictive measures.'* (human rights)	Nurses recognise service users' right to be treated less restrictively, and for service providers to engage in ethical and values-based interventions so that dignity of service users remains central.	Understanding behaviour Human rights	
RNLD 10	*'A robust risk assessment is needed to make sure that when a patient is admitted on a particular ward that the ward is where this person should be.'* (human rights)	A PBS-informed process to patient-admission is crucial in identifying suitability of the ward and ensuring the patient receives care in the right environment with the right support.	Understanding behaviour Human rights	
RNLD 18	*'We also link it back to, like, quality of life and, like, ensuring like participation in activities.'* (human rights)	The recovery process of a patient based on PBS practice ensures patients' full engagement in their care.	Understanding behaviour Human rights	

RNLD 19	*'we worked very long in the positive behavior support model to keep him at home.'* (human rights)	On this occasion PBS was successful in the community and therefore patients living outside of a hospital setting should have the same opportunity to have PBS plans.	Understanding behaviour Human rights	
RMN 3	*'I think PBS works; it has worked but yet I think it was not communicated well to the staff.'* *'I think it's all good to plan and that's it and leave the plan up in the air really, but I think it's an on-going assessment and on-going communication with the patients, it has to be.'* *'So, what I would do is make sure the team is communicating well, delegate properly, that is, support workers, key workers; monthly meetings, fortnightly meetings, to then discuss how is it working, what do we need to do; delegating to other staff and engage in team effort.'* *'Not to minimise the significance of working within a team where staff support each other and also having someone senior to ensure the team is unified…*'(Leadership)	As a framework PBS cannot work alone. It requires several factors to have the desired outcome. A team working with clear aims and objectives can support its application. A level of co-ordination is required to ensure that any PBS plan works; it must be regularly discussed and communicated appropriately. Various elements/factors need to be part of a systematic and structured strategy in order to generate a co-ordinated and concerted method of practice evaluation. Nurses place considerable importance on support systems within teams and the formation of a stable and supportive team ethos. A team that works well together requires proper management and clear leadership.	Leadership MDT approach	Communi cation
RNLD 5	*'Psychologists have to work closely with others, including nurses as we are the ones who are with the service users most of the time. So, we are important in this process. Nurses need to be consistent with PBS approach too. A lack of consistency and poor communication can become barriers in PBS overall.'* (MDT approach)	In the context of PBS, the formation of an MDT within mental health services was significant for the long-term treatment and rehabilitation of service users.	Leadership MDT approach	
RNLD 11	*'There will always be an issue specially in a learning disability sector. However, you can overcome that problem somehow by being available and making all of the reasonable adjustment with the patients so that communication does not become a barrier.'* *'It is all written; it is typed and printed. There are also pictures and it is done in an easy-read style. The patient will have a copy; staff will keep a copy as well. We have got a folder where all the*	PBS may face a number of challenges especially in areas of complex needs. Strong leadership helps address these challenges so that PBS does not become accessible to only a few.	Leadership	

	PBS plans are kept for reference and handover between teams.' (leadership) *'So, we have PBS discussion every two weeks. This is where the whole MDT meet to discuss PBS implementation on the ward. Ward staff attend.'* (MDT approach) *'Quite useful to hear from different disciplines and expertise that people were using PBS in many different ways with their clients so that was quite good.'* (MDT approach)	There are examples of PBS being implemented in a structured manner where there is a governance structure that oversee that this is always the case. The management of PBS intervention obviously requires individuals who act as leaders. In some areas MDT input supports the implementation of PBS. There are areas where the MDT and other stakeholders have been actively involved in the implementation of PBS. some areas an MDT	MDT approach	
RNLD 15	*'We explained the whole approach to the patient and staff so that we are consistent and clear about what we wanted to achieve.'* *'…but I think nurses or other staff could lead the project, and being supported by a tea….'* (MDT approach)	Irrespective of who leads PBS, an MDT presence and co-ordination is required for the intervention to be successful.	Leadership MDT approach	
RNLD 6	*'We need consistency, continuity and effort from each and everybody within a team for the intervention to work. This is what we are looking to achieve as, at times, we have people who will do something for a month and then if they do not see any changes within a short period of time they go back to what it used to be.* (leadership) *'I think I would need the support from MDT to start with. MDT is very hierarchical to certain extent. So, we need to change the way MDT functions.'* (MDT approach)	PBS can sometimes be seen as unsuccessful and ineffective especially when there is a lack of practice leadership that would guide the process with clear accountability A new way of working is needed from an MDT perspective that is not about status or power but the best interest of patients and for the advancement of PBS	Leadership MDT approach	
RMN 9	*'More about a team approach and I would want to see everybody contributing to the model rather than having one discipline leading its implementation.'* (leadership) *'So, I would nominate somebody who would oversee the implementation so that would be one thing that I would want to see in practice.'* (leadership)	To achieve a structured and multi-agency approach to PBS, there is a real need for leadership and commitment from experienced individuals. It is crucial that service users take the centre stage in PBS-as by doing so, it may initiate the whole concept of consumer leadership in care.	Leadership	

	'A PBS plan also helped to bring back responsibility to the service user because they would take ownership of their care.' (leadership)			
	'Also making sure that nurses are working in collaboration with everybody else including psychologists and medical doctors so that there is a full MDT approach to the implementation of the framework.' (MDT approach)	Nurses are given the task to ensure there is an MDT approach to PBS practice. This could be because of nurses' ability to ensure patients form part of the decision-making process.	MDT approach	
	'Nurses have the background that could be useful in the implementation of PBS and psychologist would need to embrace that knowledge and work together.' (MDT approach)	Nurses need recognition from others and appreciation for what they can contribute regarding PBS.		
RMN 2	*'PBS was implemented successfully in one particular ward where I worked, and this is because staff believed in the intervention. The ward was also well run with very clear and strong guidance from senior colleagues. When I was transferred onto a different ward, although PBS was advised this never was a success. We need people to lead but also to have a top-down approach as much as a bottom up strategy.'* (leadership)	Able to compare and explain PBS practice from two different wards where she worked. She observed the success of PBS on one unit but not on the other. Her analysis of the situation was that the absence of a leader to drive PBS forward was gravely felt.	Leadership	
	'Furthermore, in learning disability services where PBS is widely used there seems to be better coordination and more team effort with the right attitude from the team.' (MDT approach)	Wherever there is a systematic approach to PBS, there is a strong MDT working, which can be argued that PBS can bring a team together.	MDT approach	
RMN 8	*'Plans need to be communicated properly not just amongst staff but more importantly with service users/patients and carers. It's so important to get people on board- in particular patients.'* (leadership)	The attainment of true co-production where patients are engaged at every stage of PBS intervention, rests on robust governance arrangement.	Leadership MDT approach	
RMN 4	*'Leading will entail much more such as the formulation of PBS, working together and bringing people together for the best interest of service users.'* (leadership)	The leading of PBS was argued to involve assuming roles and key responsibilities including bringing people to work together to improve the care of service users; and having systems in place to ensure PBS is implemented effectively.	Leadership	
	'Communication between different professions, service users and staff, and carers, [and] family members are very crucial in the implementation of PBS. We cannot have a system whereby one	It was established that interactions and engagement between professionals, carers and service users was indispensable for the good functioning of PBS.	MDT approach	

	person decides, and then there is no consultation, no discussion or exchange of ideas, views and opinions with others. Good communication brings consistency and reinforces the validity of the intervention.' (MDT approach)			
RNLD 12	*'When there is a paperwork regarding PBS it is better for all of us to sit and discuss including psychologists, nurses to sit and talk.'* (leadership) *'We need stronger collaboration. every time when the psychologist wants to do something, they must have a small meeting with the nurses before they even go to the patients – and also to involve the patients more in their care.'* (MDT approach)	On-going discussion between disciplines is essential for PBS to be effectively implemented. This is possible when different members of the team come together in discussing and co-producing through someone in charge. Patient engagement is of extreme importance in the care provision, but nurses play a valuable role contributing to the discussion. Therefore, this has to be appropriately recognised.	Leadership MDT approach	
RMN 14	*'There is something important lacking: the right attitude.'* (leadership) *'You should not let anything stop you from implementing things like PBS because it's part of the care package we manage.'* (leadership)	For PBS to become a framework that delivers what it promises to achieve, professionals need to have the right attitude. Individuals with experience and certain authority can help change attitude to one that sees PBS as scientific evidence-based framework.	Leadership MDT approach	
RMN 17	*'…this creates the link that helps with the co-ordination and prevents any breakdown in PBS care. we also provide a lot of support to the provider.'* (leadership)	The co-ordination of PBS is paramount in any situation it is being used. Clear harmonisation of different activities within the framework can be facilitated by someone with the skills and competence.	Leadership MDT approach	
RNLD 7	*'This is not to say that nurses cannot do the same (i.e. involved at that level) – and I think it has to be a team approach.'* (MDT approach)	Nurses are important within an MDT and have the capabilities to undertake and support any task, as long as it is organised by the MDT.	Leadership MDT approach	
RMN 1	*'The MDT agrees to a plan of how we support service users with challenging behaviours so then PBS works well.'* (MDT approach)	When PBS is designed and delivered after proper MDT input, it has shown good results, especially in challenging situations. This shows the effectiveness of collaborative working.	Leadership MDT approach	

RNLD 10	*'Having the input of different stakeholders would make the plan a bit more robust but also that would be some more commitment that was the fulfilment of the plan.'* (MDT approach)	A holistic PBS plan where relevant parties have contributed to its development can lead to a more cohesive MDT.	Leadership MDT approach	
RNLD 19	*'In planning those strategies, and therefore it's so important that you involve with others.'* (MDT approach)	PBS consists of a number of interventions and it is important to recognise that different expertise and interest from multiple disciplines is paramount.	Leadership MDT approach	
RNLD 6	*'with PBS it's about looking at the bigger picture and…how we can, as nurses, as support workers get to understand the client and see how our actions, and how the environment interacts with that client.'* *'So, we had a signature chart, whereby each and every time he (service user) behaved himself he would receive a signature per shift. So, each and every time there was no shouting or swearing, they would sign to say that he had been good. He knows if he gets around 25 signatures then he will be rewarded with something that he likes. One of these rewards could be money towards a trip or for something he wanted to purchase.'* (reduces challenging behaviour) *'So, my first and proper use of PBS was [a]ward where we had a patient who, the way he deals with demands and asking for things, is usually by shouting and swearing…'* (reduces challenging behaviour)	PBS allows a greater understanding of how various factors affect the care of a patient. Within a PBS plan there is often a reward plan that helps with the behavioural aspect of an individual. This approach works when all of the other factors that affect the individual's presentation, are taken into consideration. A reward system was, therefore, often included in PBS plans. Participants talked about the usefulness of the tool in behaviours that challenge. The effectiveness of PBS in some cases is determined by the reduction of violent or challenging behaviour.	Multi-component Reduces behaviours that challenge Appraisal of a new construct	Effectiveness
RMN 9	*'It is supposed to be supporting the individual rather than being punitive or infringing on people's human rights.'* *'PBS favours simplicity in the sense that the language that is used is clear simple and it identifies the behaviours that needs to be addressed and it also provides 'how?' as much as the 'when?' and 'by who?'.'* *'I think anxiety and fear around the unknown is something that needs to be addressed.'*	It is accepted that PBS is mainly about the ethical use of interventions to help patients with complex needs without using restrictive interventions as a first resort. PBS is effective when it is delivered in its simplest form without any sophistication. A clear and simple PBS plan will need to have the relevant information to help the patient and many stakeholders supporting the patient.	Multi-component Reduces behaviours that challenge	

	'I accept that PBS could be useful in the community, given the presentation of many of our service users.' (appraising a new construct) *'Where does it come from and why it has to be implemented in such away…'* (appraising a new construct)	Optimism that PBS could be useful in community services; while there is on-going discourse on the need for staff to know more about the framework. Nurses are still asking a number of questions about PBS that remain to be answered in a clear and concise way.	Appraisal of a new construct	
RNLD 7	*'There should be an overview of all concepts; and PBS should not, as any other interventions, be used independently.'* *'I do not think PBS on its own is enough to achieve objectives. There is always need to have person-centred approach to care and PBS provides that.'* (multi-component) *'PBS is a very useful framework that works really well in specific situations.'* (reduces challenging behaviour) *'PBS could well be relatively new approach that would need to be evaluated and appraised before staff could embrace it.'* (appraising a new construct)	There is the recognition that PBS cannot and should not be considered as the answer to all issues in mental health or LD services. PBS can form part of other interventions. An individualised approach is much needed. In areas of challenging behaviour, PBS is found to be useful The presentation of PBS as an evidence-based practice and a framework that works in many areas, should have been the starting point.	Multi-component Reduces behaviours that challenge Appraisal of a new construct	
RMN 14	*'That's why the decommissioning of the seclusion room happened, so, PBS does really work.'* '*There are examples of violence, aggression and other restrictive interventions that can be avoided with the effective use of PBS.'* (reduces challenging behaviour) *'PBS is about improving quality of life as not everybody display behaviour that challenge.'* (reduces challenging behaviour) *'Moreover, not enough is being done to raise awareness.'* (appraising a new construct) *'You cannot expect everybody to be aware of PBS.'* (appraising a new construct)	PBS can bring major changes in practice if applied accordingly and with all the support that is needed. PBS has shown that some of the practices could have been avoided or deemed unnecessary if evidence-based practices had been used. There is great emphasis on PBS being effective in reducing challenging behaviour, which is one of the factors that enhances QoL of patients in mental health services. It will be beneficial for staff to know and understand the principles of PBS. Nurses want to be familiar with this new framework in mental health services.	Multi-component Reduces behaviours that challenge Appraisal of a new construct	

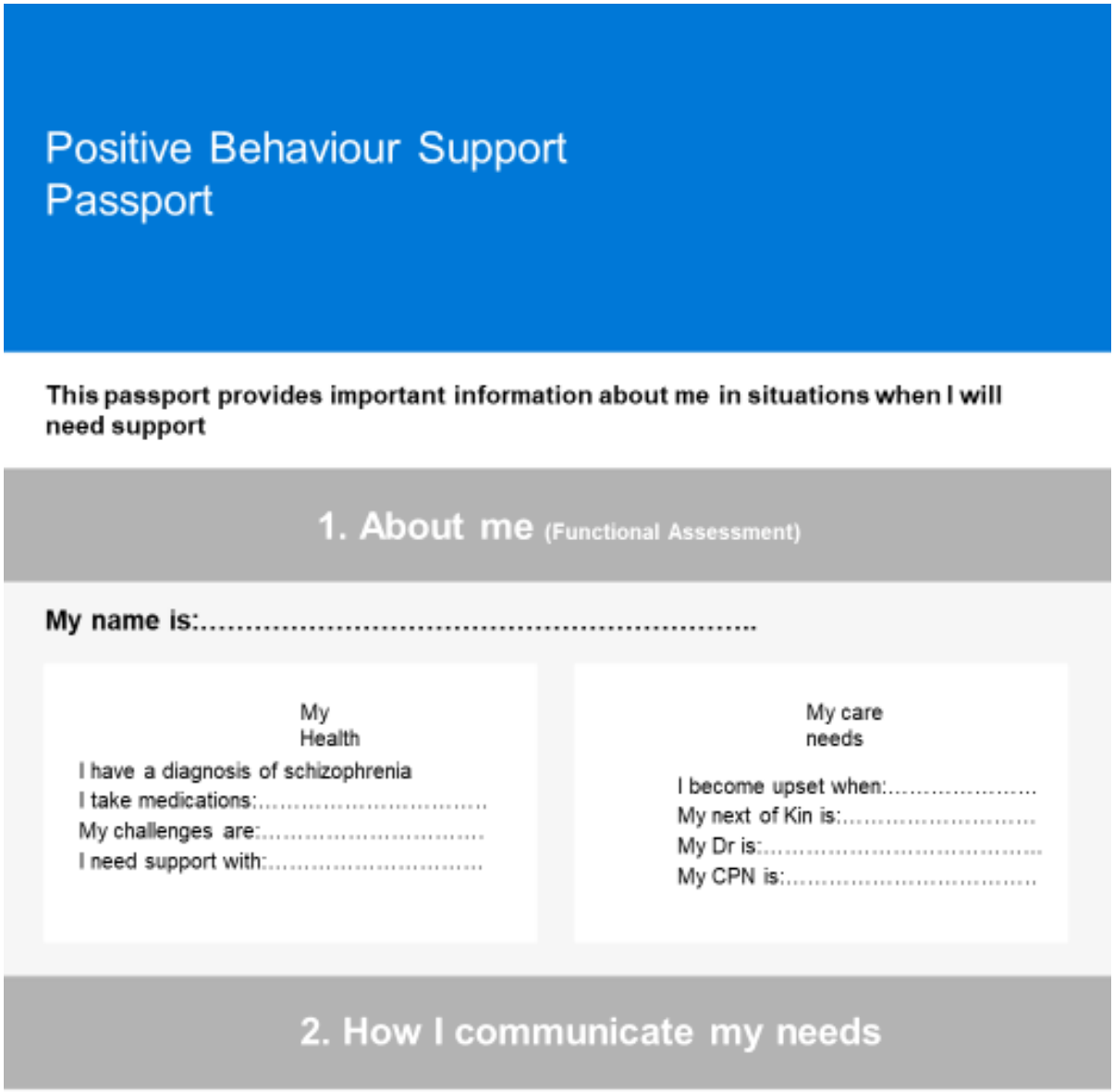
RMN 1	*'What I think: caring for someone with behavioural problems, challenging behavioural problems, I think you can have other interventions with PBS. PBS does not solve all the problems of challenging behaviour because what I understand is that PBS is a multi-composed framework; and it should be used alongside other interventions for it to become effective.'* (multi-component) *'If I could remember we used PBS with one of our clients. This client had very challenging behaviour. He couldn't engage, and he always wanted everything to be done promptly, so it became a problem; but after having a meeting with the MDT there was a plan that came up. There was a positive behaviour plan that was suggested, which we tried, and it worked.'* (reduces challenging behaviour)	There are a number of interventions available to help individuals, and PBS needs to part of the list of interventions as it has shown its effectiveness. Identifying issues at an early stage is a key aspect of PBS whereby patients' needs are highlighted so that there can be a plan in place to meet these needs.	Multi-component Reduces behaviours that challenge Appraisal of a new construct	
RMN 3	*'With time, we have learnt and understood that PBS is a framework that entails several interventions. One example is for staff to have a good understanding of challenging behaviour and few practices that engage service users in meaningful activities.'* (multi-component) *'The positive thing is that service users enjoy music, they like to go out; so, it is about getting them extra community leave. They have one community leave as it is, may be getting extra community leave as long as they behave.'* (challenging behaviour) *'I think what I have come across is that it is good to start very early, you know once you see someone behaving in an irrational way, it is good to start immediately not to leave it late.'* (challenging behaviour)	Felt that PBS consisted of a system that rewarded service users – motivated and incentivised good behaviour. According to these nurses, an absence of PBS training undoubtedly brought confusion to the approach, which subsequently had an impact on PBS delivery. Moreover, it was felt that confusions about their role and the level of intervention required from nurses blurred the process. Understood PBS as a reward-based approach and described the process as giving service users what they wish.	Multi-component Reduces behaviours that challenge Appraisal of a new construct	
RNLD 5	*'Going back to the original question; staff appreciate that PBS is not just one practice; it consists of a series of practices, but also of staff being mindful of a number of factors that contribute towards successful implementation of PBS. It is a package, isn't it?* (multi- component)	A good understanding of PBS as a multi-component framework that favours a holistic approach.	Multi-component	

	'For me, PBS is an effective way to address challenging behaviour – not sure if it is the only way, but it certainly works with many individuals. In the case that I cited earlier we have seen that PBS had decreased restrictive practices, less challenging behaviour.' (challenging behaviour)	Recognises PBS as a significant practice in areas of behaviours that challenge, and further acknowledges that PBS may not be the only framework.	Reduces behaviours that challenge Appraisal of a new construct	
RNLD 10	*'PBS is quite effective but there are other interventions or model of intervention but could be equally useful in challenging environment*' (multi-component)	There are many interventions that could help in challenging situations and PBS is one of them that should be actively supported.	Multi-component Reduces behaviours that challenge Appraisal of a new construct	
RMN 8	*'There are other interventions that could also be used. A wide range of tools are already available on wards. 'Working as a team is significant for any framework to work.'* (multi-component) *'While PBS remains a new concept, it needed proper training for staff to familiarise with the model.'* (appraising a new construct) *'While PBS remains a new concept, it needed proper training for staff to familiarise with the model. Staff were using PBS without any particular thought. Therefore, the full effect of the model wasn't felt in areas where there was no training.'* (appraising a new construct)	PBS is a relatively new framework in some areas of care and this argues that the organisation should provide the required support for staff to embrace it, so that patients could benefit, albeit in a community setting. Staff should not be left to understand a new intervention without support in place.	Multi-component Reduces behaviours that challenge Appraisal of a new construct	
RNLD 18	*'Have like being able to try and apply the strategies at home.'* (multi-component) *'I would say it's a good tool to use for children with learning disabilities and autism and behaviour problems.'* (challenging behaviour)		Multi-component Reduces behaviours that challenge Appraisal of a new construct	
RMN 2	*'Of course, with challenging behaviour it is more useful, but it causes no harm for everyone to have one. Particularly with service users who can potentially become challenging.'* (challenging behaviour)	PBS recognised as a useful framework where there is a history of challenging behaviour, and additionally in cases of potential risk of developing this behaviour.	Multi-component Reduces behaviours that challenge	

	'On ward there was a general lack of interest in PBS, but the practice was linked to service users' rewards, such as having leave etc.' (challenging behaviour)	The provision of rewards is a way of positively reinforcing good behaviour.	Appraisal of a new construct	
RMN 4	*'We get the patients to sign the chart, as a signature is required, at the end of the shift for good and bad behaviour and if behaviour was not positive then the chart is not signed, which eventually means the service user will not get a reward.'* (challenging behaviour) *'So, for me it's been a very useful tool to help patients deal with their behaviour [of concerns] on the ward and helping patients to kind of change behaviour which is hard to deal with.'* (challenging behaviour) *'PBS has been a very useful tool to help patients deal with their behaviour like challenging behaviour on the ward and helping patients to kind of change behaviour which is hard to deal with. PBS is a kind of a plan to help patients move on in their care.'* (challenging behaviour)	Explaining her experience of working with individuals whose behaviour she found complex, where PBS was used to focus on the issues. Confident about PBS and describing its positive effects on service users, supporting them through difficult behaviours and complex needs. Moreover, expressing views of PBS as a channel through which service users made progress in their respective care pathways.	Multi-component Reduces behaviours that challenge Appraisal of a new construct	
RMN 16	*'This approach is properly centred to that person who is at risk of behaviour that challenge or any other disruptive behaviour.'* (challenging behaviour)	PBS is seen as deeply rooted in the management of behaviours that challenge.	Multi-component Reduces behaviours that challenge Appraisal of a new construct	
RNLD 12	*'This is new to many of us. We are still learning a lot about it and I think there should be continuing support in this journey.'* (appraising a new construct)	As a new construct for many nurses, the full impact of PBS is still being evaluated in practice.	Multi-component Reduces behaviours that challenge Appraisal of a new construct	
RNLD 11	*'I value the informal discussion because staff is more receptive, and PBS is put into context which is the practical aspect of the new model.*' (appraising a new construct)	Nurses appreciate and value the on-going support provided to them to better understand PBS and its application.	Multi-component Reduces behaviours that challenge	

			Appraisal of a new construct	
RMN 15	*'Some staff did not see the importance of PBS and also in some cases it being something new to the ward and not being used before.'* (appraising a new construct)		Multi-component Reduces behaviours that challenge Appraisal of a new construct	

Appendix 15: A PBS Passport



Positive Behaviour Support Passport

This passport provides important information about me in situations when I will need support

1. About me (Functional Assessment)

My name is:.....

My Health

I have a diagnosis of schizophrenia
I take medications:.....
My challenges are:.....
I need support with:.....

My care needs

I become upset when:.....
My next of Kin is:.....
My Dr is:.....
My CPN is:.....

2. How I communicate my needs

When I am upset and worried I :

Isolate myself

May start to shout at others

Start to pace and become stress

May become verbally abusive to others

3. Strategies that work for me

When I am upset, worried or stressed, I like someone to:

- Find a quiet place, away from any noise or distraction
- Use simple and clear verbal communication
- Offer me a 1:1 to let me talk about my feelings

- Offer me something that I enjoy doing, i.e. play computer games
- Listen to me and offer reassurance
- Find ways to distract my thoughts of anger/stress
- Offer me a cup of tea with biscuits

- Be aware of my PBS plan
  Know who to contact to seek further support
- Know my risk assessment
- Offer me medications if I become too upset

4. My likes and dislikes

These are some of the things that I like and dislike. Ask me and I will tell you more

Do

- Speak to me calmly and slowly
- Speak clearly and with a positive tone
- I like staff who are respectful
- I like to drink tea and eat biscuits

Don't

- Talk too loudly
- Ignore what I say to you
  Disrespect me
- Minimise my concerns
-

5. Important contact details

These contact details are relevant

Speak to: XXXXXX

Write to: XXXX

Send an email to:

Call XXXXXXXX

If found please return to: XXXXX

Appendix 16: Preliminary research findings on NHS trust research newsletter

Research Department
BEH-MHT

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust
A University Teaching Trust

RESEARCH NEWSLETTER
Spring/Summer 2019

CONTENTS

User Submitted Feature

A Phenomenological Exploration of Nurses' Experience of Using Positive Behaviour Support

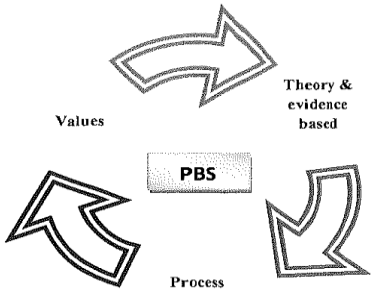
by Darren Savarimuthu

Darren is a nurse, currently in role as Preceptorship and Mentorship Lead at Barnet, Enfield and Haringey Mental Health Trust. His research relates to the use of Positive Behaviour Support (PBS) in supporting individuals who display behaviours of concern.

In the United Kingdom a number of inquiries were set up to investigate the care of people who display challenging behaviour. These included the Winterbourne View (2012), the Commission for Healthcare Audit and Inspection (2006), and the Commission for Healthcare Audit and Inspection (2007). These reviews suggested a need for urgent reform in this area of our care services. Additional comments were expressed and these were around the commissioning of services for people who exhibit challenging behaviour; and changes in practice were considered as long overdue.
In 2011, an undercover reporter from the British Broadcasting Corporation (BBC) went to the now-defunct Winterbourne View hospital following concerns of abuse.

The reporter's findings were shown on the BBC panorama programme Undercover Care: The Abuse on 31st May 2011, which then became known as the Winterbourne View scandal. The concerns were related to physical, emotional and psychological abuse of vulnerable individuals with learning disabilities who challenged services

Consequently, the impetus to reducing restrictive interventions and practices in care settings, more particularly in areas of mental health and learning



disability became quite evident at this juncture.

Further to Winterbourne, PBS became the preferred choice, as a framework, that reduces the risks of service users being treated the way they did. PBS is described as a behavioural approach that is non-aversive and less intrusive. It is predominantly used, with good effects, in areas of challenging behaviour. PBS comprises of primary, secondary and reactive strategies. The primary strategies place emphasis on changing unwanted behaviours while the reactive aspect of the framework provides a process of addressing challenging behaviours when they occur. Therefore, unlike other behavioural strategies, PBS has its main focus on stopping behaviour from

taking place; by understanding why a particular challenging behaviour occurs in the first place (function of that behaviour); what are the triggers to that behaviour. A functional assessment and analysis are vital components of PBS.

During a literature review it became evident that there is a lack of research that evaluates nurses' experience of PBS. It is vital that nurses' views are sought on this intervention as they are often in the forefront of violence, aggression and challenging behaviour.

This study therefore aimed at filling the existing gap in the evidence base. The objectives of this study include:

- Generating new knowledge and contribute towards the existing body of evidence on PBS.
- Exploring the potential implications of the findings in learning disability and mental health services.
- Filling the gap that exists in current literature that explores nurses' views and experience in relation to PBS.

A total of six registered practitioners comprising of four mental health and two learning disabilities nurses were interviewed using semi-structured interviews.

The verbatim of the data was transcribed, analysed and interpreted by hermeneutic phenomenology. The emerging themes were codified through thematic analysis assisted by computer software NVivo version (11) for data storage and manual coding.

The six themes that emerged were:

- TRAINING
- RESOURCES
- PSYCHOLOGY LED PRACTICES
- RESTRICTIVE PRACTICES
- EFFECTIVENESS
- COMMUNICATION

The nurses recognise PBS as an effective framework in supporting individuals with challenging behaviour. They believe prior PBS experience, knowledge and training are essential elements for a consistent approach. The participants also formed a view that appropriate communication and leadership in practice are contributing factors in the successful delivery of PBS.

Further, there is a perception that PBS helps towards the reduction of restrictive practices. A lack of resources was identified as a potential risk to the smooth implementation of PBS and it was observed that the intervention is psychology led.

This paper has been accepted for publication in the Mental Health Practice Journal under the heading 'Exploring Nurses' Experience of Positive Behaviour Support using Hermeneutic Phenomenology' (2019)

Interested in having your own feature in the newsletter?

Contact ayesha.dar@nhs.net to find out more.

Appendix 17: Published article – service improvement project

A quality improvement project to reduce restrictive interventions in a mental health service

Abstract

Background/aims This article describes a quality improvement project that aimed to reduce restrictive interventions on an acute psychiatric ward. In light of a service level agreement and based on a trust-wide target, the purpose of the project was to reduce restrictive interventions by 20% within a period of 6 months. It was also anticipated that a least restrictive environment could have a positive impact on patient experience.

Methods Three evidence-based interventions were introduced to the ward during the quality improvement project. These included positive behaviour support, the Safewards model and the productive ward initiative.

Results There was a 63% reduction in restrictive interventions over a 6-month period through the successful implementation of a series of evidence-based interventions to manage behaviours that challenge on the mental health ward.

conclusions The project identified collaborative teamworking, staff training and adequate resources as essential elements in the success of the quality improvement initiative. However, co-production was found to be crucially significant in bringing sustainable changes in ward environment and in addressing restrictive practices.

Key words: Challenging behaviour; Mental health; Physical restraint; Quality improvement; Restrictive interventions; Seclusion

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Introduction

The Department of Health (2014) describes restrictive interventions as limiting or confining the movement of individuals and reducing someone's liberty and freedom. Some commonly used restrictive interventions in mental health include physical restraints, seclusion and segregation, including enhanced observation, although this is found to serve limited benefits in cases of self-harm (Reen et al, 2020). Other forms of restrictive interventions comprise the administration of rapid tranquilisation medications and the overuse of 'as required' medications (NHS Protect, 2017). Restrictive interventions are often used to manage patients who present as violent and aggressive (ie verbal and physical abuse). These are based on the perceived needs to control and manage patients' aggressive behaviour; but also to take control of situations that may present immediate risks to patients (Kinner et al, 2017).

In a mental health context, other restrictive interventions may include locked wards. Locked wards provide limited access to internal and external facilities and the term locked wards may also refer to practices that stop someone from doing what they wish to do. In most cases, restrictive interventions are undertaken as last resorts in order to safeguard the patient. A last resort situation is when no other intervention has produced positive outcomes in a specific context (Kelly, 2017; Power et al, 2020). A restrictive intervention in this perspective is inevitable, particularly when a prompt intervention (such as physical restraint) is required to save life. However, in such a scenario, physical restraint should be values-based, outcome-focused, dignified, and respectful to the individual receiving the experience, and should be used as an absolute last resort (Department of Health, 2014).

Nonetheless, there are nationwide concerns when physical restraint and seclusion are practised as primary interventions, because of the abusive nature of such practices and the lack of awareness of the impact of these interventions (Bowers, 2014; Bowers et al, 2016). Correspondingly, the incidents at Winterbourne and Whorlton Hall have caused anger and a renewed determination to clamp down on the use of restrictive interventions in health care (Taylor et al, 2017; Triggle, 2019). The most subtle restrictive intervention, such as enhanced observations, could be equally traumatic for patients when used inappropriately (Reen et al, 2020).

Physical restraint has never been an ethical, moral or preferred way of managing behaviours that challenge (Hawkins et al, 2005; Kynoch et al, 2011). The application of physical restraint has attracted much criticism for being unsafe, and it exposes patients to a variety of risks, injury, abuse and death. The death of David Bennett, who was physically restrained to the floor in a compromised position (ie face down in a prone position) (Blofed, 2003) is an example of the serious risk of physical restraint (Cockerton et al, 2015; Duxbury, 2015), as is the death of Geoffrey Hodgkins, a 37-year-old mental health inpatient who was in an NHS hospital (Duxbury, 2015). Since the death of David Bennett in 1998, 13 people have died from being restrained. Patients have expressed a feeling of distress and trauma following the application of physical restraint on their persons (Kynoch et al, 2011).

Similarly, physical intervention has left nurses feeling undignified and emotionally disturbed with the practice. Allen and Tynan (2000) reviewed staff experience when caring for individuals who are in a challenging environment where physical restraints have been used. The staff described this as anxiety provoking and distressful. In addition, nurses in particular have found physical restraints distressing and humiliating (Bigwood and Crowe, 2008). Moreover, nurses have stated that they feel uneasy with the overreliance on pro re nata (which means as required) medications. They have suggested that using pro

re nata medications should be reviewed, as well as exploring the provision of an approach that is therapeutic with long-term positive effects (Barr et al, 2018). Similarly, 99% of nurses have voted against the use of physical restraint (Royal College of Nursing, 2013).

In instances where seclusion and restraint are avoided, there tends to be an increase in the administration of rapid tranquilisation medications (Georgieva et al, 2012; Steinert et al, 2014). Therefore, while there is a drive to clamp down on the use of one type of restrictive intervention, it seems that another form of restriction increases. Within this context, patients have often described the effects of pro re nata medications to be similar to physical restraint as they both have serious debilitating effects on their demeanour (Ridley and Jones, 2012; Niven et al, 2018).

Literature review

A literature review was performed, using the electronic databases:

- Cumulative Index of Nursing and Allied Health Literature (CINAHL)
- MEDLINE
- PsycINFO
- PsychNet-UK.

These databases are classified as essential in the review of qualitative studies in the field of nursing and healthcare (Wright et al, 2015). Flemming and Briggs (2007) have reported and supported the effectiveness of CINAHL, MEDLINE and PsychInfo in the search for evidence in healthcare.

Different search terms as guided by Hart (2012; 2018) and Aveyard (2010) were used. The initial stage was to assess the breadth and range of literature available. This step gave a sense of the volume of literature available on restrictive practices and quality improvement that was relevant to nurses' experience.

The terms 'restrictive practices' and 'restrictive interventions' were used as primary search terms, as they are both often used interchangeably in the literature and could yield data that otherwise would have been missed. Boolean search operators and the truncation operator * were used. The following terms were finally included in the search strategy:

Restrictive practic* AND Restrictive interventions OR review OR Quality Improvement OR Evaluation OR Audit OR Seclusion OR Restraint OR rapid tranquilisation OR coercion OR Mental illness OR Challenging behav*

The outcome of the literature review demonstrates limited peer-reviewed published literature on quality improvement projects aim at reducing restrictive practices in acute

mental health wards. The literature search found 78 articles that made reference to quality improvement work in relation to restrictive interventions or practices. However, when this search was limited from 2014 to date, only two articles came up. The limitation of 2014 onwards was because of the publication of *A Positive and Proactive Workforce: A Guide to Workforce Development for Commissioners and Employers Seeking to Minimise the Use of Restrictive Practices in Social Care and*

Health (Department of Health et al, 2014), which emphasised the reduction of restrictive practices in care services.

Methods

Setting

The project took place at a London-based mental health NHS organisation. The ward selected for this quality improvement review was an acute psychiatric mixed ward of 20 beds. This particular ward was involved because it had a relatively high level of restrictive interventions. **ethical approval**

This quality improvement review was deemed a service improvement project; therefore, ethical approval was not required. However, the project was recorded as such with the research and development department of the NHS organisation. All patients were fully informed of the study and the implications on their care. They gave their verbal consent and fully understood that the project was about improving their care.

Co-production

The delivery of some of the approaches in this quality improvement review was co-produced by patients. Co-production surpassed the mere presence of patients at different stages of this project or the interventions, and certainly patients were not by-standers throughout the different decision-making processes. In fact, it has involved a power-sharing approach between patients and the multidisciplinary team in an environment of flattened hierarchy (Rose et al, 2018). Nevertheless, there were a number of challenges to the co-production of this project; some of these were around barriers to culture change and lack of appropriately trained and skilled staff. In this quality improvement review, not all the patients wished to make decisions about the process. This was partly because of a lack of capacity or acuity of their illness. However, these individuals were engaged at various levels where they felt comfortable participating.

Plan-Do-Study-Act cycle

The Plan-Do-Study-Act cycle is a commonly used methodology in healthcare quality improvement projects in the UK when compared to other methodologies such as six sigma and lean (Christoff, 2018). The four steps or stages of the cycle provide an iterative process for quality improvement in order to achieve a successful outcome. The Plan-Do–Study-Act cycle offers opportunities to test a proposed change and serves as a powerful tool for learning from ideas that did not work. It consists of a series of interventions to test an idea by trialling a change on a small scale, allowing for changes to take place and assessing their impact, building upon the learning from any previous cycles of change in a structured way before implementing the intervention (NHS Improvement, 2018).

By applying this methodology to this study, the process of change was safer and less disruptive for patients and staff (NHS Improvement, 2018). While implementing changes on the ward, staff were given coaching support, participated in teaching and learning sessions, exchanged ideas and listened to success stories and stories where things did not work out as planned. Patients were fully supported to engage with the change ideas.

Overview of the change ideas

A series of evidence-based interventions were introduced to the ward during the quality improvement project. These included positive behaviour support, the Safewards model and the productive ward initiative. These models are widely recognised as useful and effective in addressing behaviours that challenge in mental health and learning disability services (Gore et al, 2013; Department of Health, 2014; Bowers et al, 2015; Robert et al, 2020).

Positive behaviour support

Positive behaviour support is a non-aversive behavioural approach that improves quality of life and is recommended by the Department of Health (2014). The model provides sets of evidence-based interventions that consist of proactive measures to support service users with complex needs who display behaviours of concerns (Padden, 2016). The positive behaviour support model is composed of primary strategies (actions that prevent the occurrence of certain behaviours), secondary strategies (verbal de-escalation) and reactive strategies (used as a last resort and may involve use of medications or physical restraints). Therefore, the emphasis of primary strategies is on meeting individuals' needs; the proactive approach is to minimise behaviours of concerns, while the reactive aspect of the framework provides a process of addressing behaviours that challenge when they occur (Positive Behavioural Support Coalition UK, 2015).

Safewards

Safewards is described as a model that is evidence based and found to be effective in reducing conflict and containment in mental health environments (Bowers, 2014; Bowers et al, 2014). The model has six key domains and 10 interventions that focus on the principles of patient recovery. **Table 1** displays the domains and interventions.

Productive ward

The NHS Institute for Innovation and Improvement launched the productive ward initiative in 2008 under the title *Releasing Time to Care*. The principal aim of the productive ward is to identify and reduce activities that are not meaningful and add no value (Morrow et al, 2010). The initiative is for frontline workers to critically review their work using a bottom-up approach so they can restructure their work to release time to spend with patients (Gainsbury, 2009). The productive ward initiative may look into the amount of paperwork that nurses undertake, duplication of tasks, teamworking and any gaps, patient experience and satisfaction level and quality time spent with the patients (Fillingham, 2007).

Table 1. Domains and interventions of Safewards model

Domains	
	The patient community
	Patient characteristics
	Regulatory framework
	The staff team
	Physical environment Outside hospital

Interventions	
	Clear mutual expectations
	Soft words Talk down
	Positive words Bad news mitigation
	Know each other
	Mutual help meetings
	Calm down methods Reassurance
	Discharge messages.

Table 2. Model, interventions and measures

Model	Interventions	Measures
Positive behaviour support	Functional assessment Individualised positive behaviour support plans Occupational therapy and psychology Use of ABC charts.	Positive behaviour support training Learning from other organisations and networking Staff reflective groups Patients' involvement and participation.
Safewards	Use of the 10 domains set by Bowers (2014).	Safewards awareness training Patient engagement.
Productive mental health ward	Equipping staff with systems and tools to improve care.	Protected time for staff and patient engagement Changing ward environment Releasing staff to care by cutting paperwork Patients' evaluation through satisfaction surveys.

A co-produced approach and teamworking were at the centre of the interventions and multidisciplinary team input was pivotal to the success of the project. **Table 2** illustrates some of the key interventions from the three models that were tested on the ward. The practices became embedded in the day-to-day delivery of therapeutic care all at once, rather than being a standalone periodic intervention.

Data collection

Data relating to restrictive interventions were recorded 3 months before the study began and 6 months after the study.

Datix

Datix, the incident reporting system, was used during data collection. However, in order to triangulate and ensure that data were being recorded appropriately, all incidents of restrictive interventions

including violence and aggression were recorded on safety crosses. This method has ensured rigour in the data collection. Similarly, incidents of physical restraints and seclusion as a result of behaviours of concern were recorded as normal practice.

Patient satisfaction survey

Patient satisfaction surveys were completed on a weekly basis and by doing so this ensured that patients had time to evaluate and make sense of any changes on the ward. The anonymised patient survey was produced in an easy-to-read version to help patients complete it. These surveys were designed in a bespoke manner to address the questions or issues particular to the ward (available from the authors). For instance, one of the questions was around safety on the ward and their perception of violence and aggression on the unit. The surveys were analysed independently by the quality team for reliability.

Patient safety crosses

Safety crosses were daily collection tools that were used on the ward to collect the data in addition to the Datix system. Silverton (2012) argues that safety crosses provide patients and staff the opportunity to express themselves in a systematic way; they give a chance to access thoughts and feelings that occur, despite patients appearing 'settled'. Further, representing feelings visually can be a safe way of showing emotion. It was agreed that if a patient had a good day this was represented in the colour green, whereas a bad day (ie any restrictive practices was imposed as a result of seclusion, physical restraint or

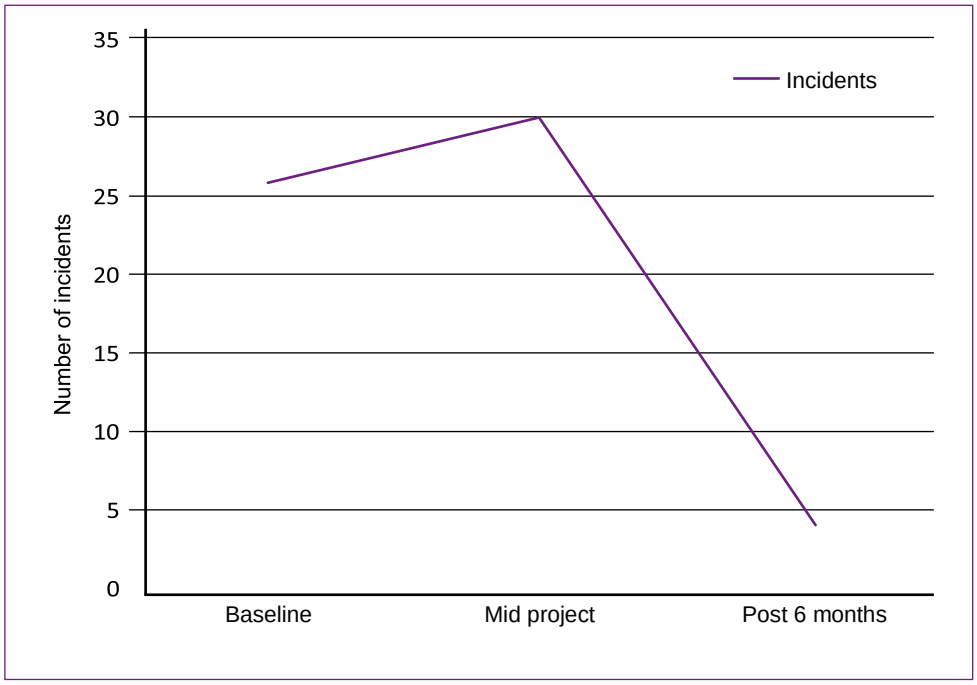

Figure 1. Restrictive interventions

aggressive behaviour) was coloured red. The use of colours was not intended to reduce or undervalue individuals' behaviour and concerns, rather the colours were in line with the traffic light system already being used in the healthcare system to describe feelings and behaviour (Hollomotz and Caviezel Schmitz, 2018).

Staff and patients were encouraged to use different colours on the relevant crosses each time they had a bad experience. Such an experience would be subjective and mainly based on any event that could have affected the patient's safety on the ward as a result of violence or aggression.

Results

During the project, 13 incidents of physical aggression were recorded on Datix, which was reflected in the safety crosses. At the start of the improvement work, the number of restrictive interventions and physical assault was 26. During data analysis and when comparing incident reports before and after the study, it was found that the number of violent and aggressive incidents significantly reduced in the first 4 months and continued to decrease to the end of the 6-month period. This reduction in violence and aggression has had a direct influence on the use of restrictive interventions on the ward, with about 63% reduction in the use of physical restraint, seclusion and use of rapid tranquilisation. Incidentally, there was an 88% decrease of verbal abuse towards both staff and patients. The safety crosses and the patient experience surveys triangulated the findings. **Figure 1** shows the changes in the number of physical incidents including restrictive interventions on the ward.

Discussion

The positive behaviour support and Safewards models, together with the productive mental health ward initiative, were used on a mixed psychiatric acute ward to reduce restrictive interventions and incidents of violence, which fell by around 63% within a 6-month period. The implementation of positive behaviour support and Safewards, and the completion of the safety crosses were not without its challenges. The productive ward initiative had a relatively smooth implementation. However, lack of staffing and resources did occasionally have an impact.

Patient satisfaction surveys

The patient satisfaction surveys drew a positive picture of the experience on the ward in relation to violence and aggression and its effect on restrictive interventions and aggressive behaviour. It was clear that the number of physical restraint and other incidents had an effect on patient experience on the ward. Restrictive interventions on the ward reduced, which included seclusion, enhanced observation and pharmacological intervention. This project did not evaluate the use of pro re nata medications on that particular ward, as further input was needed from pharmacist colleagues and this was identified as a separate piece of quality improvement work for the future. The success of this project has required practice leadership, and this was offered by the ward manager, junior staff and a dedicated quality improvement team who were committed and enthusiastic about achieving positive outcomes for both patients and staff.

Professional and patient collaboration challenges

One of the difficulties encountered was maintaining a consistent team approach to the interventions, especially when working with limited resources as a result of lack of staff, staff turnover and three different models of care, with staff and patients not being familiar with some of these models. Although staff were offered training and a certain level of preparedness to work with these models, there were moments of confusion and uncertainty from staff. This was addressed through a weekly reflective group session and ongoing supervision. Healthcare professionals often miss the opportunity to work collaboratively with each other and this is particularly the case when practising in a complex health care environment (Morgan, 2017). An unsettled environment inevitably creates a situation where patients

may not fully benefit from the care that they are meant to receive if treatment is not implemented through a collaborative process (Ham and Davies, 2018). What was required during this project revolved around the development of suitable professional collaboration in the presence of practice leadership, where staff are tasked to bring teams and individual professionals together for the benefit of services and patients (De Vries, 2016). However, it was imperative to understand the reasons as to why professionals arguably do not work together all the time. While a difference in professional cultures could be one of the reasons for this separateness, there was also the effect of the complex environment in which different professions work (De Vries, 2016). Therefore, it was vital for different professions to appreciate each other so that the care outcomes delivered through a team effort were improved (Brown et al, 2015).

A further challenge was that positive behaviour support is not widely used in mental health. Therefore, it was considered essential for the staff working with this model to have full awareness training of positive behaviour support. While the model yielded positive outcomes in this case, there was a risk of infidelity to the framework as it is not widely available in mental health (Clark et al, 2020). However, for any model of care to succeed, it is essential for staff to build and maintain therapeutic relationship with patients and family members. Engaging relevant stakeholders in the delivery of care where patients are at the forefront of the decision-making process remain pivotal in the Trust. In this instance, co-productivity ensured that patients were involved at each and every level of the change ideas and the quality improvement process. This has involved education, training and regular feedback opportunities with patients.

Benefits of therapy-related interventions

The Department of Health (2014) guidance on reducing the need for restrictive interventions emphasises the benefits of therapy-related interventions in challenging situations. This service evaluation has reiterated a possible link between appropriately implemented models of care and the reduction of restrictive interventions particularly affecting individuals who exhibit behaviours that challenge. The contribution of this article is twofold with regard to restrictive interventions. First, it suggests that positive behaviour support and Safewards may be deemed suitable models that help to reduce restrictive interventions, particularly following the incidents at Winterbourne and Whorlton Hall.

Second, positive behaviour support and Safewards can arguably assist in situations where power, control and hierarchy within a care system could be addressed, while encouraging co-production and consumer leadership. The productive ward model was centred around making sure that staff had assigned specific roles at the start of each shift following an informative handover. The ward undertook a review of all enhanced observations to ensure that staff were released from these interventions to be able to provide meaningful activities on the ward.

Seclusion-free practice

With regard to patient-centred care, safeguarding, seclusion and segregation in mental health services, positive behaviour support and Safewards may provide an environment where patients are cared for in a dignified manner. However, similar to these models, other interventions need to be explored that are least restrictive, ethically correct and socially and legally acceptable. Ideally, a seclusion-free practice is the way forward, but this is not always easy to achieve, especially in challenging environment where staff feel the practice is necessary to maintain safety, and is supported by NHS policies, guidelines and

legislation (Happell et al, 2012). Most seclusion incidents are often as a result of physical restraint (Kaar et al, 2017). Both staff and patients find the experience of physical restraint and seclusion upsetting, stressful and dehumanising (Kinner et al, 2017). Therefore, an environment where there is no seclusion would have an impact on the occurrence of physical restraint (Cummings et al, 2010).

A strategy that could support the concept of seclusion-free practice is the development of a therapy-focused approach to care with a shift from the biomedical model that exists (Faulkner, 2017). One of the challenges that may become apparent is that tranquilisation medications could be used instead of seclusion (Noorthoorn et al, 2016). The overuse of medications and protracted hospital admissions in mental health services remain ongoing concerns where patients may be subject to episodes of unnecessary restrictive interventions (Haw and Wolstencroft, 2014). For instance, as at June 2020, 60% of patients in learning disability services have been hospitalised for over 2 years (NHS Digital, 2021). This article may provide an argument for a recovery-based pathway for patients.

Close monitoring and governance over the use of medications may help review its use and identify areas where this could be a regular practice, and to ensure that measures are in place to facilitate a culture change around the use of rapid tranquilisation where it is used only when clinically necessary. A working group or forum could be effective if this is set up in a way that it invites ideas, provides an opportunity to challenge practices and engages practitioners, patients, carers and other significant stakeholders. A limited attempt has been made to eliminate the use of seclusion and restraint through an engagement model in mental health services (Blair and Moulton-Adelman, 2015); however, it has not been tried expansively as there are concerns over safety, security and duty of care. A model, inclusive of positive behaviour support, that could be used to reduce seclusion and restraint should have the input of nurses as leaders, because they are often the professionals who take the decision to seclude patients (Faschingbauer et al, 2013; Savarimuthu, 2020).

Physical restraint as a last resort

Some professionals have described restrictive interventions such as physical restraint as a necessary evil, which they say is part of their job as an important aspect of providing care (Wilson et al, 2017). Although staff accept that physical restraint is not pleasant, many are of the view that it remains a necessary intervention when working in difficult situations (Bigwood and Crowe, 2008). Correspondingly, Wilson et al (2017) do not advocate the elimination of physical restraint, but propose that its application is only used as a last resort during extremely violent behaviour. From this particular viewpoint, it seems clear that the debate around physical restraint continues in the backdrop of legal, ethical, moral and social aspects of the practice.

Recommendations for practice

In addition to evidence-based practices in mental health services, staff attitude, training, support and leadership are all essential requirement to reduce restrictive interventions. Co-production is embedded in a therapy-focused recovery process, where patients have a leadership role and take ownership of their care. However, advocacy services, family

Key points

- Restrictive interventions are often used to manage patients who present as violent and aggressive (verbal and physical abuse). They are based on perceived needs to control and manage patients' aggressive behaviour; but also, to take control of situations that may present immediate risks to patients.
- A quality improvement project was carried out that aimed to reduce restrictive interventions on an acute psychiatric ward.
- A series of evidence-based interventions were introduced to the ward during the quality improvement project. These included positive behaviour support, the Safewards model and the productive ward initiative.
- The number of violent and aggressive incidents significantly reduced in the first 4 months and continued to decrease to the end of the 6-month period. There was a reduction of about 63% in the use of physical restraint, seclusion and use of rapid tranquilisation.
- The findings show that restrictive interventions can be reduced with the implementation of evidence-based practices, good leadership, and an effective co-productive approach.

support network and organisational changes to empower patients are necessary measures to be in place for individuals who may need support to co-produce their care.

Staff training in behaviours that challenge and trauma-informed care remain critical components in the effective management of difficult situations. It can potentially influence staff attitudes towards restrictive interventions in mental health services, and how it affects the recovery of patients.

Resources and a lack of appropriately trained staff can impact on the delivery of any therapeutic intervention; therefore, the recruitment and retention of staff should be conducted in a systematic and robust manner. In addition, supportive clinical supervision from senior members of staff is deemed necessary to develop the resilience and confidence of junior staff.

Limitations

This quality improvement project is limited to one ward with specific issues as detailed. In this project there was the implementation of three different models to improve care. Therefore, it was not possible to assess the effectiveness of each intervention individually as they were as they were all implemented at the same time.

Conclusions

This quality improvement review looked at three interventions to reduce restrictive intervention on a mixed acute mental health ward. The findings show that restrictive interventions can be reduced with the implementation of evidence-based practices, good leadership and an effective co-productive approach. This quality improvement review was undertaken on one ward where staff had a set of skills, competence and enthusiasm to deliver the aim and objectives of the study. However, this may not be the case in a different setting. Nevertheless, appropriate training, leadership, supervision and reflective groups are all important aspects to consider.

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conflicts of interest

The authors declare that there are no conflicts of interest.

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Appendix 18: Published paper on Covid-19

Exploring the experiences of student mental health nurses from ethnic minority backgrounds working through the COVID-19 pandemic: a phenomenological approach

Abstract

Background/aims The COVID-19 pandemic has impacted individuals from ethnic minority backgrounds more than any other group. The purpose of this study was to explore the experience of mental health students from ethnic minorities who worked during the COVID-19 pandemic in a mental health NHS trust.

Methods This study used phenomenology as the theoretical framework and thematic analysis as a method for data analysis. Data were collected through semi-structured interviews with 12 student mental health nurses, which were held via Microsoft Teams.

Results The four themes that emerged from this study were altruism, a sense of connectedness, support and learning opportunities, and role clarity. Students described a sense of altruism while deciding to opt-in to the extended placement. Some also found their faith to be a source of support and resilience, which provided a sense of connectedness. Support was an essential element that emerged in this study where students could rely on both the university and the mental health NHS trust. The learning opportunities that COVID-19 has presented have helped bridge the gap between the physical and mental wellbeing of patients; however, a lack of clarity in their roles was highlighted.

conclusions Adequate and appropriate policies and guidance to support student nurses are needed when working in crisis situations.

Key words: Ethnic minority; Experience; Nurse education; Phenomenology; Student nurses

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Introduction

The COVID-19 virus was first detected in Wuhan, China in 2019. The virus quickly spread around the globe to become a pandemic. Since early 2020, many people have died worldwide, and the UK is one of the countries that has recorded high COVID-19 cases and mortalities (Jackson et al, 2020). In the UK, it was anticipated that there would be pressure on NHS services. In preparation of such an event, the UK government, in consultation with chief nursing officers, Health Education England and the Nursing and Midwifery Council, agreed for student nurses, particularly those in their final 6 months of their programme, to undertake extended clinical placements to support services while also completing their learning (Nursing and Midwifery Council, 2020). As the effects of the pandemic gradually unfolded, it became apparent that staff who were ethnically diverse were most affected. A Public Health England report exploring the impact of COVID-19 on ethnic minority communities highlighted the impact of COVID-19 on the ethnic minority healthcare workforce (Fenton et al, 2020). There is evidence suggesting that the COVID-19 pandemic has had a significant impact on the mental

health of individuals (Liu et al, 2020; Usher et al, 2020). A systematic review conducted by Vindegaard and Benros (2020) found that health workers had a high level of psychological and psychiatric symptoms.

Data show that the fatality rate among health workers who were from black, Asian and minority ethnic (BAME) groups was 64% (Chaudhry et al, 2020). The figure was 94% for doctors and 64% for nurses (Cook et al, 2020). In the UK, the first 11 deaths that were recorded among doctors from the NHS were from BAME groups (Kirby, 2020).

It has been shown that COVID-19 has discriminately affected people from BAME groups more than any other ethnic group (Khunti et al, 2020, Rimmer, 2020). Therefore, NHS staff from BAME backgrounds were considered most at risk when working on the frontline (Kirby, 2020). Additional analyses have shown that health workers from ethnic minority backgrounds were disproportionately affected by COVID-19, with high death rates (Bhatia, 2020). A UK review on the impact of COVID-19 found that death rates from COVID-19 were higher for people from black and Asian ethnic groups than for people of British white ethnicity (Public Health England, 2020).

This study focuses on the experiences of mental health nursing students from one university, where 95% of final year students who opted into extended clinical placements were ethnically diverse.

Aim

The aim of this study was to explore the experiences of students from BAME backgrounds while they were supporting teams or services in one London mental health NHS trust throughout the first wave of the pandemic.

Objectives

- Explore students' concerns, if any, before the start of the placement and while working during the peak of COVID-19.
- Explore the support that students received in practice and if anything could have been different.
- Provide recommendations, based on the participants' comments, to improve experiences of students from ethnic minorities in the clinical environment.

Methods

Literature review

Before developing the research question, a scoping exercise was undertaken through Google Scholar to assess the extent of literature that was available on the subject. Limited research was found that captured the experiences of student nurses from ethnic minority backgrounds during the first wave of COVID-19. A literature review was then conducted using several databases to answer the research question of 'what are the experiences of student nurses from ethnic minorities during the COVID-19 pandemic?'. The databases searched were CINAHL, Medline, EMBASE, EMCARE and PsychINFO. The Patient, Intervention, Comparison and Outcome (PICO) guide was used to facilitate the literature search as follows:

P: student nurses from ethnic minority backgrounds

I: COVID-19

C: mental health and learning disability wards

O: experience

Further to this exercise, a systematic approach was taken to search and review existing research on the topic. The development of the search terms was facilitated through the PICO guide. Boolean operators OR, AND and the truncation mark (*) were used with the following terms:

COVID-19 OR coronavirus OR 2019-ncov OR sars-cov-2 OR COV-19 AND student nurs* AND ethnic minority OR BAME OR racial minorities OR ethnic groups OR minority groups AND Experience OR attitude OR evaluation.

The inclusion and exclusion criteria set for this literature review are shown in **Table 1**.

The literature search focused on research from 2018 onwards. By using the search terms, there was no literature that focused specifically on the experience of student nurses from BAME backgrounds who volunteered to work during the COVID-19 pandemic. This process identified a gap in the literature. However, the scope of the literature search was expanded to capture all student nurses' experience of working during the pandemic. There

Table 1. Inclusion and exclusion criteria	
Inclusion criteria	**Exclusion criteria**
2018 onwards	Registered nurses
Relating to COVID-19 Peer-reviewed academic journals	Opinion paper Systematic review
Abstract available Full text available	Debates
Qualitative research	
Quantitative research	
Ethnic minority BAME	
English language Student nurses	
Mental health or learning disability Research	

were 354 articles in the initial search, after applying the inclusion and exclusion criteria, eight studies that were published in several countries were relevant to student nurses' experience directly related to COVID-19:

- UK: Swift et al (2020), Godbold et al (2021), Kane et al (2021)
- USA: Howard et al (2021)
- Spain: Collado-Boira et al (2020), Gómez-Ibáñez et al (2020), Casafont et al (2021),
- Belgium: Ulenaers et al (2021).

The themes from the existing literature on student nurses' experience of COVID-19 were:

- Impact of the pandemic and their commitment
- Risks, knowledge, fears and infection prevention
- Support system
- Nurse training.

Methods

study design

The methodology used in this study was phenomenology, which is described as a theoretical framework that helps to understand the experience of individuals (van Manen, 2016). Phenomenology was first introduced by Husserl (1970), who described it as the study of lived experience. Phenomenology is also commonly explained as possessing the primary intention to describe phenomena through interpretation (Klein and Westcott, 1994; Cohen et al, 2000). It is a methodology that explores the lived experience of individuals, or groups of people with similar experiences (Crotty, 1998; Creswell, 2007; van Manen, 2016). Furthermore, it is widely acknowledged as an approach that explores the lived experience of others in a way that can be understood by the individuals themselves (Cohen et al, 2000; van Manen, 2014). This methodology has become quite popular and well-used in nursing research because it offers a unique approach to help others to understand people's experiences (Cohen et al, 2000; Ho et al, 2017).

Phenomenology tends to unveil phenomena and is designed to unfold experiences that have remained obscured or unexposed, but most importantly it provides a framework to explore experiences and analyses the meaning of those phenomena. In this study, phenomenology helped the participants reflect on their experience of working during COVID-19 and provided the participants with an opportunity to tell their experiences in their own words.

ethical approval

This research was deemed to be a service improvement work; therefore, ethics approval was not required. However, the organisation research and development department was in support of this study. The university, in particular the mental health nursing department where the students were studying, was also advised of this research and fully supported this project. All participants provided written informed consent.

Participants

Participants were informed of this study through their university and through trust emails. One senior trust staff member, who was not involved in the study, was appointed as the gatekeeper so that students had a first point of contact. This was to ensure that potential participants could openly discuss the research and their involvement without any perception of bias. This process ensured a systematic and open approach at the recruitment stage of the study. All participants were in the final year of their nurse training to become mental health nurses. Limited information is provided about the participants to maintain their confidentiality. A total of 12 students volunteered and were found eligible to take part in this study, satisfying the inclusion and exclusion criteria set out in **Table 2**.

Data collection

Semi-structured interviews provided a degree of flexibility at the data collection stage but focus groups could have initiated a much profound discussion. A total of 11 interviews were undertaken using Microsoft Teams software, and one was undertaken face to face. Each participant was interviewed by the main researcher, while a second researcher was taking additional notes as required. Each interview lasted a maximum of 1 hour and was recorded on Microsoft Teams.

Risk assessment

Given the context of the study and the effects of COVID-19 on healthcare workers, the participants were provided with additional support if this was necessary. The mental health NHS trust put a psychological support structure in place for reflective sessions as and when needed. The support structure was independent of the research team. It is to be noted that no participants requested additional support following the interviews. The researchers maintained contact with the students after the interviews to ensure their wellbeing. There was a debrief after each interview to make sure participants had an opportunity to reflect. During the one face-to-face interview, relevant infection control measures were in place to ensure the safety of the participant and the researcher. No consent was given for a second researcher to be present, and this was respected.

Data analysis

The transcripts from the semi-structured interviews were analysed using the hermeneutic circle and the six stages of thematic analysis as described by Braun and Clarke (2006). The transcripts were read and manually coded by the main researcher, then discussed with the other researchers to ensure a consistent approach was taken and reliability was maintained.

Table 2. Participant inclusion and exclusion criteria

Inclusion	Exclusion
Student nurses	Registered nurses
Anybody who considered themselves to be from an ethnic minority group	Student nurses who did not class themselves as being in an ethnic minority group
Students in their final year	
Students who volunteered for an extended placement during COVID-19 Students who worked at the frontline during the pandemic	

Table 3. Participants' characteristics

Participants	Sex	Age range (years)	Method
1	Female	40–45	Microsoft Teams
2	Female	40–45	Microsoft Teams
3	Female	35–40	Microsoft Teams
4	Male	60–65	Microsoft Teams
5	Female	35–40	Microsoft Teams
6	Male	45–50	Microsoft Teams
7	Female	35–40	Microsoft Teams
8	Female	35–40	Face to face
9	Female	35–40	Microsoft Teams
10	Female	30–35	Microsoft Teams
11	Female	20–25	Microsoft Teams
12	Female	35–45	Microsoft Teams

throughout the process. The notes taken by the second researcher were used during data analysis to ensure that the participants' accounts were accurately reflected and captured.

Results

Participants

A total of 12 students took part (women *n*=10, men *n*=2). **Table 3** details their demographic characteristics and how the interviews were carried out.

Themes

The four themes that emerged were:

- Altruism
- Sense of connectedness
- Support
- Learning opportunities and role clarity.

altruism

The participants felt a sense of duty during the pandemic and they heard the call from their profession to join frontline carers in the fight against the virus and to help others during a challenging time. One participant described the nursing profession as:

> **'… a career you have to live for others.' (Participant [P]1)**

The participants felt that their presence was needed more than ever to care for and protect their patients. One way of doing this was through providing reassurance at a time when they felt unsure:

> 'I wanted to reassure the patients. I can't come there making them feel afraid.' (P2)

While there was a sense of duty during the pandemic and the student nurses wanted to be support patients and other staff, there was an element of risk, upset and stress. However, patients' needs were the utmost priority for the students:

‘I was a bit upset because we were risking our lives. But at the end of the day, we had our patients as a priority.’ (P10)

sense of connectedness

When things became difficult as the pandemic progressed, the student nurses working on the frontline needed a sense of connectedness.

The majority (*n*=9) held on to their spiritual and religious beliefs for courage and strength.

‘I was praying every day. Encouraging myself with the word. I kept my head above the water. I have to pray, draw my strength from my faith. Everybody is afraid.’ (P8)

Many found their family, the university and their social network to be extremely important in difficult times. Information sharing regarding personal protective equipment, knowledge and information about the virus and infection control information were all useful resources.

‘Family, university. Everybody just needs that support. That’s what we were doing, sharing information.’ (P6)

‘As I said, most of my strength came from my family. We believe in prayer. My wife said, “Don’t worry”. My wife is a prayer warrior as well.’ (P4)

support

No participant raised anything different that could have been put in place to improve their experience while working during the pandemic. While all the participants have reflected on how the pandemic impacted on their academic, personal and social life, there was no suggestions of how work experience could have been better. This could be perhaps because nobody has had previous experience of working during such a worldwide phenomenon.

The students felt that they could not have continued to work during the COVID-19 pandemic if they had not been supported. Such support took the form of trust updates on the pandemic, university support and regular team meetings with students. Being provided with relevant information in a format that was easy to understand and with some clarity was welcomed.

‘It was quite challenging. I am high risk as well. I had a lot of information. I had read about it. My previous practice assessor gave me information.’ (P4)

The university played an important role in providing ongoing support to the students. Information on the virus came thick and fast and it was a challenge to keep updated on a daily and weekly basis. Students felt well supported by the university during their placement and that support was also coming from the trust.

‘Oh yes, they did give us information. They gave us placement requirements. Information about Covid … and wellbeing support.’ (P3)

Issues around personal protective equipment (PPE) and ethnic minority groups being mostly affected by the virus created a lot of anxiety among the student nurses. Some students had gone through the grief of losing close friends and colleagues. Working in this condition was challenging, but the support from colleagues was acknowledged.

‘I had a lot going on in my head. Especially when I saw the news about the lack of PPE and BAME staff dying after my colleague also died. I spoke to my practice assessor about it. She was giving me support. Yes, she is experienced, and she understood.’ (P11)

‘The more information we received on the virus, the more I was able to understand how to protect myself.’ (P7)

Working as a team was another way of supporting each other during the pandemic and this was clear from the student nurses. They felt that managerial support and frontline support was beneficial.

'We supported each other, our manager was there for support, we grew better as a team.' (P11)

Learning opportunities and role clarity

Another reason for the students' willingness to work during the pandemic was to consolidate their learning. The pandemic provided an opportunity to bring parity of esteem between physical and mental health. Some students were ready to take the challenge and push their learning.

'Gaining confidence with the M[ental Health] Act, caring for elderly adults, a lot of physical care needs, being there for 6 weeks was not enough as a student, 3 months' experience made me more confident. Auditing was done as a "band 4", which is also something I had little experience with.' (P11)

Some students talked about their leadership skills and how they had an opportunity to further develop this and to put this into practice:

'I can remember an example … one night, all the nurses called in sick. They got somebody from the bank [temporary staff], and I took lead. He was impressed. Everything went well. If I had been supernumerary [there to learn not as a member of staff], I wouldn't have been able to do all that.' (P12)

At times, there was a sense of lack of role clarity. Some students felt that while they wanted to learn new skills and become competent as part of their journey to become a registered nurse, there was a sense that they were working as registered nurses and healthcare assistants.

'I did not want to make decisions on my own but I was the only one there and I felt a big responsibility on me.' (P9)

Discussion

From the literature review, it is evident that no study seems to have explored the experiences of student nurses from BAME communities during the pandemic. The student nurses in the present study decided to opt-in despite having been afraid of contracting the virus coupled with the impact on ethnic minority groups. In Collado-Boira et al's (2020) study, students described a sense of nervousness and fear, including a feeling of uncertainty during the time that they were working as frontline staff. However, students in general have had moments of doubt, fear and exhaustion while working during the pandemic (Swift et al, 2020; Aslan and Pekince, 2021; Godbold et al, 2021; Kane et al, 2021).

The present study provides some evidence of the participants' motivation, compassion and genuine interest to care, and it became evident why they wanted to join the nursing profession – there is a sense of pride to have contributed to the healthcare system during a time of need. This is reflected in other studies (Gómez-Ibáñez et al, 2020; Leigh et al, 2020; Swift et al, 2020; Casafont et al, 2021).

The pandemic has provided an opportunity for student nurses to develop new skills and some of them perhaps would not have gained these skills if they had been on placements before the pandemic. While on extended placements, the participants in the present study had been involved in the constant and ongoing physical health monitoring of patients who had COVID-19. In addition to providing care for patients with mental illnesses, the participants had to maintain their knowledge and competence regarding physical health. Swift et al (2020) found that students thought the experiences rewarding yet challenging. However, there was a sentiment that they were undervalued. This ties in with the students in the present study stating that there was a lack of role clarity on their placements.

The students in this study spoke about the support that they have received from their family members, the organisation, university and referred to the power of prayers. Casafont et al (2021) referred to coping mechanisms and teamworking as essential. The comments and experience of the student nurses in the present study, in relation to their spirituality and belief system, seems to be unique as it has not been mentioned in the studies identified in the literature review.

Recommendations

This study does not propose separate support networks for ethnic minority staff. However, studies (Godbold et al, 2021; Kane et al, 2021; Ulenaers et al, 2021; Casafont et al, 2021) including this one have highlighted support systems to be crucial in time of crisis. It is therefore fundamental that the trust continues to review its policies, protocols and guidance in line with national standards so that the information available remains up to date for student nurses and other colleagues from ethnic minority backgrounds. It may be appropriate to appoint a senior staff member from the trust to oversee all of the support systems in place for student nurses, not only during the pandemic, but also for future crises that may come.

Although the participants in this study did not have any negative comments to make about the trust or their university in relation to the support that they received, a sense of fear was felt while they worked during the crisis. This experience is consistent with other studies (Collado-Boira et al, 2020; Swift et al, 2020; Casafont et al, 2021). Therefore, it may be useful to include protected time for students to come together to talk about any issues that they are experiencing. Providing an opportunity for peer support may be helpful for individuals. This could be done through a digital platform, such as Microsoft Teams.

Several students mentioned their spirituality and beliefs. These should be accommodated at both the university and trust where feasible – for example prayer rooms, or a designated quiet room if a prayer room is not available.

At a national level, the preregistration nurse training should be reviewed. It became evident during the pandemic that a competency-based training model would be more appropriate, given that third-year students were deemed competent to work, often taking registered nurses' roles and responsibilities.

Limitations

There are some limitations to this study that should be noted. The interviews were carried out via Microsoft Teams. A face-to-face interview would have been the preferred option to build rapport with the participants, although one student was interviewed face to face as that was requested by the person. The researchers were from the nurse education team; therefore, this may have influenced the outcome of the interviews where participants may have felt reluctant to criticise services or any lack of support, although the lead researcher was independent of the education team. A larger sample size would have produced more data. However, given the context and challenges of a pandemic, it was difficult to recruit more students.

conclusions

This study explored the experiences of student nurses from ethnic minority backgrounds who worked during the COVID-19 pandemic. The students were afraid of contracting the virus because of the impact it has had on ethnic minority groups. Support was provided through information, and some students were supported through their belief system. Even though working consolidated their learning, the students felt that there was a lack of role clarity.

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conflicts of interest

The authors declare that they have no conflicts of interest.

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