

**Guidelines to enhance patient-centred care for mental
health care users in community psychiatric clinics in
uMgungundlovu District, KwaZulu-Natal**

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Health Sciences in the Faculty of Health Sciences at the Durban University of
Technology

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Declaration

This is to certify that the work is entirely my own and not of any other person, unless explicitly acknowledged (including citation of published and unpublished sources). The work has not previously been submitted in any form to the Durban University of Technology or to any other institution for assessment or for any other purpose.

Signature of student

Date

Approved for final submission

Prof M.N. Sibiya

Date

RN, RM, D Tech: Nursing

Abstract

Background

The implementation of the Mental Health Policy Framework and Strategic Plan 2013-2020 promotes the integration of mental health into the general health care stream, intending to reduce the stigma and discrimination associated with mental health disorders. The policy on the integration of services suggests a more holistic and patient-centred approach to nursing mental health care users (MHCUs) in community psychiatric clinics. A substantial amount of research has been done on the integration of services and patient-centred care (PCC) in South Africa. No studies have been found that were conducted specifically with professional nurses and the provision of guidelines on enhancing PCC for MHCUs in the community psychiatric settings taking into consideration the integration of services.

Aim

The aim of the study was to identify the extent to which mental health has been integrated into the general health stream and ultimately develop guidelines to enhance patient - centred care for MHCUs in community psychiatric clinics in the uMgungundlovu District, KwaZulu Natal (KZN).

Methodology

A convergent parallel mixed-methods approach was used in the current study. The professional nurses and operational managers who met the inclusion criteria were purposely included in the sample. Data collection was achieved through three phases, namely; by observation using an observation checklist, surveys in the form of individually structured questionnaires and one -on - one interviews guided by a list of pre-set questions. Data from phases one and two were analysed using the Statistical Package for Social Sciences (SPSS) Software Version 25. Descriptive statistics were used to summarise and describe the analysed data and the findings were also presented in the form of tables and

graphs. Inferential statistics were applied to identify significant trends. Data from the one-on-one interviews were coded and analysed until relevant themes and sub-themes were realised.

Findings

Professional nurses reported that the integration of services was in line with the prescripts of the ideal clinic. The policy on the integration of services was implemented although professional nurses expressed that it was not effective due to MHCUs temperament. Professional nurses that were in direct contact with MHCUs daily tried to give off their best to MHCUs and practice PCC. They reported that open communication, teamwork, appropriate nurse-patient relationships, adequate and updated in-service on PCC were essential components in the delivery of PCC. However professional nurses also faced barriers that prevented the successful implementation of PCC; namely: staff shortages, time constraints, and large numbers of patients, impatient patients and inexperienced nurses. The findings of all three phases were triangulated with the integration of the Neuman's Systems model which guided this study to assist in the development of the proposed guidelines to enhance PCC.

Key words: Community psychiatric nursing, guidelines in psychiatric nursing, holistic nursing care, integration of services, patient- centred care.

Dedication

This study is dedicated to my supportive and caring husband Jeevi, you are truly one in a zillion. To my awesome children Alisha Jade and Jared Tristen, thank you for your encouragement, love and understanding. Your motivation, patience and tolerance made my journey a more enjoyable one....I have been blessed with a beautiful family.

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Glossary of terms

Integrated health services

The World Health Organisation (WHO) defines integrated health care as “health services that are managed and delivered in a way that ensures people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services, at different levels and sites of care within the health system, and according to their needs, throughout their whole life” (WHO 2008: 1).

Primary health care clinic

A facility at and from which a range of primary health care services is provided and that is normally open eight or more hours a day based on the need of the community to be served. Accessible first-level health services are included as part of basic essential health services (KwaZulu-Natal Department of Health 2019).

Community health centre

A facility that normally provides primary health care services, 24-hour maternity, accident and emergency services and beds where health care users can be observed for a maximum of 48 hours and which normally has a procedure room but not an operating theatre (KwaZulu-Natal Department of Health 2019).

Mental disorder

A mental disorder is defined as “a broad range of problems, with different symptoms. However, they are generally characterised by some combination of abnormal thoughts, emotions, behaviours and relationships with others” (WHO 2018: 1).

Mental health care practitioner

Mental health care practitioner refers to “a psychiatrist or registered medical practitioner or a nurse, occupational therapist, psychologist or social worker who has been trained to provide prescribed mental health care, treatment and rehabilitation services” (Republic of South Africa 2002: 6).

Mental health

Mental health is defined as “a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (WHO 2018: 1).

Mental Illness

Refers to “a positive diagnosis of a mental health related illness in terms of accepted diagnostic criteria made by a mental health care practitioner authorised to make such a diagnosis” (Republic of South Africa 2002: 7).

Mental health care user

Mental health care user refers to a “person receiving care, treatment and rehabilitation services or using a health service at a health establishment aimed at enhancing the mental health status of a user...” (Republic of South Africa 2002:6).

Operational Manager

An operational manager is a professional nurse that has been officially appointed in that post to manage a unit or clinic (Muller 2000: 45).

Patient-centred care

Berwick (2009: 559) defines patient-centred care (PCC) as “the experience (to the extent the informed, individual patient desires) of transparency,

individualisation, recognition, respect, dignity and choice in all matters, without exception, related to one's person, circumstances and relationships in health care”.

Professional nurse

According to the Nursing Act 33 of 2005, a professional nurse is a person who is qualified and competent to independently practice comprehensive nursing in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice (Republic of South Africa. 2005).

List of acronyms

Acronym	Full word/sentence
CHC	Community health centre
HIV	Human Immunodeficiency Virus
ICSM	Integrated Clinical Services Management
IPHC	Integrated Primary Health Care
KM	Kilometres
KZN	KwaZulu-Natal
MDT	Multi-disciplinary team
MHCA	Mental Health Care Act
MHCU	Mental Health Care User
NCS	National Core Standards
NGO	Non-Governmental Organisation
NQF	National Qualifications Framework
OM	Operational Manager
OPD	Outpatients Department
PCC	Patient-centred Care
PHC	Primary Health Care
PLWMD	People Living with Mental Disorders
PMB	Pietermaritzburg
PN	Professional Nurse
RDP	Reconstruction and Development Programme
SA	South Africa
SAMHP	South African Mental Health Policy Framework and Strategic Plan
SANC	South African Nursing Council
SPSS	Statistical Package for Social Sciences
UK	United Kingdom
USA	United States of America
WHO	World Health Organisation

CHAPTER 1: OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND TO THE STUDY

Patient-centred care (PCC) and person-centred care are concepts that are used interchangeably. Inevitably they mean the same thing, whereby the patient or person is placed first when it comes to their well-being. PCC is not a new concept, however in recent years it has emerged as an integral component in the delivery of quality patient care (Bolster and Manias 2009; Epstein and Street 2011; Greene, Tuzzio and Cherkin 2012). According to Pelzang (2010: 912), there are many interpretations of PCC which encompass several components. The World Health Organisation (WHO) defines PCC as “integrated people-centred health services which means putting the comprehensive needs of people and communities, not only diseases, at the centre of health systems, and empowering people to have a more active role in their own health” (WHO 2018: 1). Integrated people-centred health services are an important way to empower patients, fight health systems fragmentation, foster greater coordination and collaboration with organisations. It also enables providers across health care settings, to deliver health care that is aligned with the needs of people (WHO 2018: 1).

According to the Mental Health Care Act (MHCA) 17 of 2002, the term ‘mental health care user’ (MHCU) refers to a “person receiving care, treatment and rehabilitation services or using a health service at a health establishment aimed at enhancing the mental health status of a user...” (Republic of South Africa. 2002:6).

In South Africa, the Batho Pele Principles and the Patients’ Rights Charter are directly related to PCC as well as the quality of care that is delivered (Jardien-Baboo, van Rooyan, Ricks and Jordan 2016: 397). Batho Pele translated from the Sotho language means ‘people first’. Existing evidence also shows that therapeutic relationships between health care workers, patients and their significant others are vital in ensuring that PCC is successfully implemented (Pelzang 2010; Egbe, Brooke-Summer, Kathree, Selohilwe, Thornicroft and Petersen 2014; Lewis, Stacey, Squires and Carroll 2016). Mental health has been identified as an important part of public health in South Africa, yet until recently, it has always been on the lower end of the priority list in health care. The South African Mental Health Policy Framework and Strategic Plan (SAMHP) 2013-2020 was implemented to effectively integrate mental health

care into the primary health care (PHC) system (South Africa. Department of Health. 2013). For MHCUs to benefit holistically, various aspects influence the implementation of this policy; namely a clear vision, high levels of commitment, adequate resources and support from all stakeholders (Schneider, Baron, Breuer, Docrat, Honikman, Kagee, Onah, Skeen, Sorsdahl, Tomlinson, Van der Westhuizen and Lund 2016: 153).

The Reconstruction and Development Programme (RDP) is an integrated policy framework that was implemented to promote a democratic, non-racial and a non-sexist future for all South Africans. One of the many priorities was to ensure that health care was accessible to all South Africans (Onya 2007: 233). The White Paper on the Transformation of the Health Care System in South Africa indicated that there should be comprehensive community-based health care services at all levels with mental health being integrated with PHC services (Republic of South Africa 1997: 3). This was reiterated in the MHCA 17 of 2002. However, several studies show that many challenges are faced in providing efficient mental health care services (Mkize and Uys 2004; Burns 2008; Marais and Petersen 2015). According to the WHO (2007: 5), most provinces supported the integration of mental health care into PHC, and efforts have been made to provide training for PHC nurses as well as in undergraduate nursing training, although the outcome of this training has not been evaluated.

People living with mental disorders (PLWMDs) are subjected daily to stigma and discrimination (Nxumalo and Mchunu 2017; Tlhowe, du Plessis and Koen 2017). This stigma is mainly due to ignorance and misconceptions regarding mental disorders (WHO 2010: 4). Approximately one in four people worldwide suffer from some form of mental or neurological disorders in their lifetime, making mental disorders one of the leading causes of ill health and disability. Despite the large number of people affected globally, the WHO claims that about 33% of countries allocate a mere 1% or less of their health budgets to mental health (WHO 2011: 3). Current literature reveals that mental health services have not effectively been integrated into PHC, which in turn has a negative impact on MHCUs (Kakuma, Kleintjes, Lund, Drew, Green and Flisher 2010; Ssebunnya, Kigozi, Kizza and Ndyabangi 2010).

1.2 PROBLEM STATEMENT

Due to their illness, PLWMDs are vulnerable. They are often misunderstood and as a result are subjected to discrimination and stigmatisation based on the nature of their illness (Semrau, Evans-Lacko, Koschorke, Ashenafi and

Thornicroft 2015; Quinn, Williams and Weisz 2015; Nxumalo and Mchunu 2017.). The promulgation of the MHCA 17 of 2002 together with the implementation of the SAMHP brought about much hope for people with mental disorders. The MHCA 17 of 2002 supported the integration of mental health into the general health care system and promoted de-stigmatisation. Several studies reveal that although there seems to be a clear direction in which to care for MHCUs, there still seems to be many challenges faced (Petersen, Bhagwanjee and Parekh 2000; Ramlall, Chipps and Mars 2010).

The integration of mental health into PHC promoted the ideology of a more holistic and person-centred care, whereby all needs of the patient could be addressed in one place (Funk, Saraceno, Drew and Faydi 2008: 5-8). PCC should be a part of the daily routine, so it becomes second nature to health care workers and is not seen as a tedious task (Bolster and Manias 2009: 163). With the many changes that have been proposed and implemented in mental health; it seems that the burden of ensuring that patients are cared for holistically with a patient - centred approach has been carried out mainly by nurses working in the community psychiatric clinics (Ssebunnya, Kigozi, Kizza and Ndyabangi 2010: 129). Although South Africa is committed to ensuring an integrated mental health care system, there appear to be many factors that hinder the realisation of the principle of responsiveness and integration. Health care workers are trained for a biomedical orientation towards acute care and inadequately trained for using a holistic PCC approach when dealing with mental health care issues (Marais and Petersen 2015: 18). About 21% of undergraduate nurse training in South Africa is devoted to mental health (WHO 2007: 16).

Several studies concluded that common barriers faced in implementing PCC in mental health were weak managerial capacity; poor pre-training of generalists in mental health care as well as infrastructure constraints among others (Petersen, Bhagwanjee and Parekh 2000; Ramlall, Chipps and Mars 2010; Marais and Petersen 2015). There is limited research conducted specifically on PCC and nurses in community psychiatric clinics. Whilst the emphasis is placed on ensuring that mental health is effectively integrated into the general health stream, this should not be at the expense of MHCUs and their care.

1.3 AIM OF THE STUDY

The aim of this study was to identify the extent to which mental health has been integrated into the general health stream and ultimately develop guidelines to enhance PCC for MHCUs in community psychiatric clinics in the uMgungundlovu District, KZN.

1.4 OBJECTIVES OF THE STUDY

The objectives of the study were to:

- Explore nurses' understanding of PCC at community psychiatric clinics.
- Identify barriers that prevent the successful implementation of PCC when caring for MHCUs
- Identify the strategies used to implement PCC for MHCUs
- Explore the extent to which mental health care has been integrated into PHC.
- Develop guidelines to enhance PCC for MHCUs.

1.5 RESEARCH QUESTIONS

- What strategies are used to implement PCC for MHCUs?
- To what extent has mental health been integrated into PHC?
- What changes would you propose to enhance PCC for MHCUs?

1.6 SIGNIFICANCE OF THE STUDY

With the recent emphasis placed on mental health and illness, it is an opportunistic time to look at the current issues that nurses encounter in the community psychiatric clinics. In the past, 144 MHCUs died and 1418 were exposed to trauma as a result of MHCUs being transferred to facilities that were not equipped with adequately trained staff and resources to cater for their needs. (Durojaye and Agaba 2018: 161). Issues related to mental illnesses and MHCUs need to be highlighted to enable them to live a normalised life. There have been many efforts to improve mental health services in the recent past, yet mental illness still poses a great burden on individuals, families and the community at large (Lund, Kleintjes, Cooper, Petersen, Bhana and Flisher 2011: 24). PLWMDs experience isolation, blame, labelling, stereotyping and community neglect (Nxumalo and Mchunu 2017: 208). This study aimed to investigate areas of concern related to PCC in the community psychiatric clinics, as well as the extent to which mental health has been integrated into PHC. The implementation of the SAMHP implied that this policy will improve the services to MHCUs as there would be no discrimination

and segregation of services offered to the general public and that of people suffering from a mental disorder (Lund *et al.* 2011: 25). This study attempted to determine if there have been any changes with regards to the services and care received by MHCUs and how this has impacted on PCC.

1.7 OUTLINE OF THE STUDY

The thesis comprises of ten chapters. A brief description of each chapter and the content is illustrated in Table 1.1.

Chapter	Topic	Description of the content
Chapter 1	Introduction and background to the study.	Provides an orientation to the study and background, problem statement, aims, objectives, research questions and significance of the study.
Chapter 2	Literature review.	Provides an in-depth review of the literature on PCC for MHCUs.
Chapter 3	Conceptual framework.	Presents an explanation of the theory that was used to guide the study.
Chapter 4	Research design and methodology.	Presents a description of the design and methods that guided the study.
Chapter 5	Presentation of findings: Phase 1 (Observation)	Presents the findings of Phase 1: Observation
Chapter 6	Presentation of findings: Phase 2 (Survey)	Presents the findings of Phase 2: Survey questionnaire
Chapter 7	Presentation of findings: Phase 3 (One-on-one interviews)	Presents the findings of Phase 3: One-on-one interviews
Chapter 8	Discussion of the findings	Presents the discussion of findings by providing literature that either support or refute the findings of the study.
Chapter 9	Guidelines to enhance patient-centred care for MHCUs in community psychiatric clinics.	Development of the guidelines.
Chapter 10	Conclusion, limitations and recommendations	Presents the concluding remarks, limitations recommendations for future research.

Table 1.1: Structure of the thesis

1.8 SUMMARY OF THE CHAPTER

This chapter presented the introduction and background of PCC as well as the integration of mental health into PHC. Chapter 2 will present a literature review on several studies that have been conducted on mental health care in South Africa (SA) and globally. Literature on PCC related to nursing in SA and globally is also discussed.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

Polit and Beck (2010: 170-192) state that a literature review can sometimes inspire researchers with new research ideas, which help to form the grounding for many studies. A thorough review of the existing literature allows the researcher to acquire a better understanding of a phenomenon or topic and to identify gaps in the body of research. A literature review can also assist the researcher to interpret or make sense of their research findings. Further to this, a literature review highlights the significance of a new study. Botma, Greeff, Mulaudzi and Wright (2010: 63-80) emphasised that the researcher has the ability to use the current literature at hand to effectively address the flaws or gaps in the literature which in turn will justify one's research study.

2.2 MENTAL HEALTH CARE IN SOUTH AFRICA

Mental health is defined as “a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community” (WHO 2018: 1).

Mental disorders are defined as “a broad range of problems with different symptoms. However, they are generally characterised by some combination of abnormal thoughts, emotions, behaviours and relationships with others” (WHO 2018: 1).

According to the South African Constitutional Act, 108 of 1996, every South African has the right to health care services (Republic of South Africa 1996: 4). In terms of this act, the South African government is obligated to ensure that health care services are accessible to all South Africans. In 1997, the White Paper on the Transformation of the Health Care System in South Africa was promulgated (Republic of South Africa 1997: 1-19). The White Paper reiterated the principles of the RDP which stated that:

- The health care sector must play its part in promoting equity by developing a single, unified health care system.
- The health care system will focus on districts as the major locus of implementation, and emphasise the PHC approach.

- The three spheres of government, non-governmental organisations (NGOs) and the private sector will unite in the promotion of community goals.

Studies show that the South African Department of Health is invested in ensuring that mental health has its place in the health care system (Petersen, Lund, Bhana and Flisher 2012; Sorsdahl, Stein and Lund 2012; Marais and Petersen 2015). Integrating mental health into PHC is not adequate to ensure a transformation of the health care system (Marais and Petersen 2015: 9). Evidence reveals that the high rate of mental disorders warrants interventions. According to the Strategic Plan 2010-2014, it was reported that the mental health headcount increased from 323,915 in 2005/2006 to 481,186 in 2008/2009 (KwaZulu-Natal. Department of Health 2010: 24). Mental disorders can be more debilitating than physical illnesses or diseases; therefore more attention is required to ensure that the needs of MHCUs are cared for. Further work is needed to determine what works best for South Africa (Sorsdahl, Stein and Lund 2012). Self-reflection is an essential component in the improvement of the practice of mental health. Despite there being space for discourse and conflicting ideas, these should be based on the betterment of the MHCUs. Ultimately the goal of psychiatry and mental health is to ensure that the multi-disciplinary team (MDT) works together with a shared vision of promoting mental health for all (Patel 2014: 786).

The numbers of South Africans that depend on the public health sector have steadily grown over the last few years. During 2001 to 2006, the demand for public health care increased by 10 %. By the year 2006, approximately 86% of the total population of SA was dependent on public health care (Day and Gray 2006: 370). Based on data from four provinces in SA, there are 3 460 mental health outpatient facilities, of which 1.4% caters for children and adolescents. These facilities offer services to 1660 MHCUs per 100,000 of the general population annually (WHO 2007: 11).

The South African Stress and Health study conducted from 2003-2004 was the first one to be conducted on a large scale. The study, using a sample of 4 351 adults, investigated the prevalence of common mental disorders. The results revealed that the incidence of mental disorders in SA is relatively high in comparison to other countries globally. Only eight other countries had a higher rate of anxiety disorders worldwide. There was a large difference in the lifetime prevalence of mental disorders across the nine provinces. Western Cape had the highest rate of 42%, while the lowest rate was in the Northern Cape at 29%. The most prevalent disorders were anxiety disorders (8.1%), substance abuse

disorders (5.8%) and mood disorders (4.5%). It was concluded that there were variations in the rates of mental illness, although South Africa is burdened by a large percentage of mental health disorders (Herman, Stein, Seedat, Heeringa, Moomal and Williams 2009: 339-344). In a study done by Burns (2014: 6), it was found that about 956 000 adults were living with mental disorders in the province of KZN.

2.2.1 History of mental health nursing in South Africa

In 1846, the first psychiatric hospital was opened at the prison on Robben Island which was transformed into an institution for lepers, the chronically ill and psychiatric patients. The custodial care provided was reported to be of a high standard and soon after psychiatric institutions were established throughout the country. Legislation was thereafter passed for the management of psychiatric patients. In 1913, a committee was formed to oversee the wellbeing of people with intellectual disabilities and later the mentally ill. This gave rise to the promulgation of the Mental Disorders Act of 1916 (Uys and Middleton 2014: 4-7).

Miss Iris Marwick was the first nurse to be appointed as the organiser of nursing services in the Department of Health in 1946. While she held this post, she made a substantial contribution, particularly to mental health nursing. Initially, in 1928, mental health nursing was the responsibility of the South African Medical Council. In 1944, the South African Nursing Council (SANC) was established and took over this responsibility. Psychiatric nurses were recruited from industrial schools and their training was of a poor standard as there were no classrooms or trained tutors. In 1965, a small group of psychiatric nurses commenced their training as tutors. A few years later, two universities initiated a basic, integrated degree course that included mental health nursing. This integrated model was accepted for all basic training in South Africa in 1986 (Uys and Middleton 2014: 8).

According to Gillis (2012: 79-81), the new direction in psychiatric nursing brought a better understanding of mental illness to nurses. It also, to an extent, helped to eliminate the stigma of mental illness among the profession and the community. There has been much change in the modern era of psychiatry from the 20th century. Psychiatric services offered included outpatient clinics, social, community services, occupational therapy and rehabilitation amongst others. Presently nursing education and training are in the process of implementing the new Nursing Qualifications Framework (NQF) developed for South Africa. It includes a baccalaureate degree for professional nurses and a new general staff nurse qualification which follows the global trends as well as to address the

nursing shortages and deficits in basic nursing care in South Africa (Blaauw, Ditlopo and Rispel 2014: 9).

2.2.2 The integration of mental health into primary health care in South Africa

The WHO defines integrated health care as “the organisation and management of health services so that people get the care they need, when they need it, in ways that are user friendly, achieve the desired results and provide value for money.” (WHO 2008: 1). The idea of a ‘one-stop-shop’ is supposed to further contribute towards holistic care for patients.

The National Mental Health Summit which was held in Pretoria in April 2012 was convened by the Minister of Health, Doctor Aaron Motsoaledi (South Africa. Department of Health. 2013). A team of experts was directed by the Deputy Minister of Health to draw up a policy and strategic plan to address areas in mental health. This gave rise to the SAMHP. According to Doctor Motsoaledi, the SAMHP is an important milestone in the continuous efforts to transform health care in South Africa. An integrated package of essential PHC services will be available to the entire population at the first point of contact. He further stated that mental health is an important element in achieving the government’s goal of a “Long and Healthy life for all South Africans.” The SAMHP aimed to effectively integrate mental health care into the PHC system as follows:

- To upscale decentralised integrated primary mental health services, which included community-based care, PHC clinic care and district hospital-level care.
- To increase public awareness regarding mental health and reduce stigma and discrimination associated with mental disorders.
- To promote the mental health of all South Africans through collaboration between the Department of Health and other sectors.
- To empower local communities, especially mental health service users and carers, to participate in promoting mental well-being and recovery within their community.
- To promote and protect the human rights of people living with a mental disorder.
- To adopt a multi-sectoral approach to tackling the vicious cycle of poverty and mental ill-health.
- To establish a monitoring and evaluation system for mental health care.
- To ensure that the planning and provision of mental health services are evidence based (South Africa. Department of Health. 2013).

Steady progress has been made with the integration of mental health services into PHC, yet many barriers hinder its successful implementation. The Department of Health is committed to ensuring that mental health systems are at a level of optimal functioning (Schneider *et al.* 2016: 153). The co-morbidities to mental disorders are high; therefore, attention needs to be given to mental health care in order to effectively rehabilitate MHCUs into the community. An integrated mental health service will ensure that patients can access health care in one place, which gives the patient a sense of control over their health and well-being (Schneider *et al.* 2016: 159).

Sibiya and Gwele (2009: 31-37) conducted a study on the meaning of Integrated Primary Health Care (IPHC) in KZN. Participants in the study included stakeholders from the district, provincial and national levels who were involved in some way with PHC co-ordination, as well as nurses working in the PHC setting. The analysis of the data revealed three core categories; (1) comprehensive health care, (2) supermarket approach and (3) one-stop shop. Participants perceived comprehensive health care as nursing a patient holistically and not employing a tunnel view, concentrating only on their presenting complaint for the day. Nurses should ensure that all needs of patients are met. The concept of a supermarket approach was that patients were able to access a variety of services at one clinic. This type of service is cost-effective and allows patients to take charge of their health. Finally, IPHC was seen as a one-stop shop whereby one nurse was able to meet all the needs of a patient. Maconick, Jenkins, Fisher, Petrie, Boon and Reuter (2018: 4) maintain that in order for patients to be nursed holistically and seen by one nurse who is able to cater for all their needs as suggested, it is essential that nurses are regularly updated and trained with the appropriate skills to nurse MHCUs.

Moosa and Jeena (2008: 36-43) investigated the Southern Gauteng community psychiatric services with regards to the geographical distribution, staff establishments and utilisation. Although psychiatric services were said to be integrated into PHC, at this particular establishment, the health care professionals did not actively participate in the care of MHCUs. Psychiatric nurses steered the care for MHCUs with very little support received from other members of the MDT. It was possible that new patients could wait up to six months for an appointment. Repeat patients would be assessed once a month by a psychiatric nurse and every four months by a doctor. Not all these facilities had a resident psychologist, social worker or occupational therapist. According to the ratio per patient, only 1 in 500 MHCUs had access to the MDT mentioned above. The integration of mental health into PHC suggests that nurses should be treating all patients comprehensively, yet this was not the case at this facility. The

services were still very much segregated and specific according to the patients' needs. The researchers suggested that other psychiatric clinics should be evaluated to discover the extent to which the process of integration has taken place, since it appears that it has just been a paper exercise and had not been fully implemented as proposed.

A similar study by Van Der Venter, Couper, Wright, Tumbo and Kyeyune (2008: 136-140) evaluated primary mental health care in the North West Province. The results revealed two major themes that were based on general dissatisfaction. Patients were dissatisfied with communication issues, lack of continuity and long waiting times. Sokhela, Sibiya and Gwele (2016: 42-56) concurred that problems of long waiting times and overcrowding in health facilities should be addressed to improve patient satisfaction. MHCUs expressed that they were separated from other health care users that attended the PHC and indicated a need for the visibility of more doctors. The focus was centred on the specialised psychiatric services versus the so-called supermarket services. The opinions were that the primary health nurses and doctors did not have adequate knowledge and skills to care for MHCUs. Amongst other complaints was the lack of psychiatric units and patients being discharged from referral hospitals too soon which resulted in MHCUs relapsing (Van Der Venter *et al.* 2008: 136-140).

2.3 PATIENT-CENTRED CARE IN SOUTH AFRICA

Berwick (2009: 559) defines PCC as “the experience (to the extent the informed, individual patient desires) of transparency, individualisation, recognition, respect, dignity and choice in all matters, without exception, related to one's person, circumstances and relationships in health care”.

Ensuring that the fundamental needs of patients are met is essential for any health care setting (Ulin, Olsson, Wolf and Ekman 2016; Feo and Kitson 2016; Jardien-Baboo *et al.* 2016). Despite the limited research conducted on PCC and psychiatric patients, evidence shows that PCC is a growing phenomenon in South Africa (Jardien-Baboo *et al.* 2016; Mulqueeny and Taylor 2017; Almaze and de Beer 2017). It is evident from research conducted that many components surround the concept of PCC and that most healthcare workers are aware of such, yet for various reasons this does not seem to be a part of their everyday work routine (Berwick 2009; Feo and Kitson 2016; Almaze and de Beer 2017). Challenges faced with the implementation of PCC are similar to those experienced globally. Some common challenges faced are poor communication and a lack of adequate resources. Despite these challenges, health care workers

and organisations have a responsibility to ensure that patients are nursed holistically (Almaze and de Beer 2017: 59).

The National Core Standards (NCS) is implemented in health establishments to ensure that quality patient care is delivered. The core functions of the standards are as follows:

- To develop a common definition of quality of care that is used to guide health care workers.
- To provide a benchmark against which health establishments may be assessed, identifying gaps, strengths and ways to be appraised.
- To provide a national framework enabling health establishments to comply with standards (South Africa. Department of Health 2011).

The NCS and PCC are directly related, as they both promote quality patient care ensuring that the standards are consistent and maintained. Six priority areas have been identified for improvement, namely, (1) staff values and attitudes, (2) waiting times, (3) cleanliness, (4) patient safety and security, (5) infection prevention and control and (6) availability of medicines and supplies. The seven domains of the NCS are: (1) patient rights; (2) patient safety, clinical governance and care; (3) clinical support services, (4) public health, (5) leadership and corporate governance, (6) operational management and (7) facilities and infrastructure (South Africa. Department of Health 2011). Health care workers should be working in accordance with the NCS, which will further enable effective PCC to be achieved (Maphumulo and Bhengu 2019: 2). The NCS is person-centred in its approach allowing collaboration of the MDT in the health care setting (Begg, Mamdoo, Dudley, Engelbrecht, Andrews and Lebesse 2018: 79).

In South Africa, there has always been a constant spotlight on health services, with the people of South Africa expecting a high level of service delivery. This places a huge burden on health care workers as a whole, although in most cases the personnel in the firing line are usually nurses. Nurses make up a large percentage of health services and must bear the consequences of many challenges in the workplace. According to the SANC (2018: 2), the provincial distribution of nursing manpower in KZN in relation to the population was 71 030 nurses of all categories to 11 384 722 people. Many studies have been conducted related to nurses and workplace challenges, with many challenges mirroring those faced globally. As a result of these challenges faced, studies reveal that nurses are spending less time with patients (Jennings, Clifford, Fox, O'Connell and Gardner 2015; Marais and Petersen 2015). Staff shortages as well as a lack of resources are some of the main challenges faced in health care settings (Joyner, Shefer and Smit 2014; Dawson, Nkowane and Whelan 2015).

Recently in SA, there have been many changes to the health care system from a hospital-based service to a community-based service. Due to these changes, nurses are faced with the challenges of caring for a larger number of patients, resulting in an increase in stress levels, which in turn impacts negatively on patient care (Koen, Van Eeden and Wissing 2011: 2).

According to Jardien-Baboo *et al.* (2016: 397-405), nurses believed that patients should be cared for whilst taking into consideration their psychological, physical, social, emotional and spiritual aspects. Nurses stated that in order for them to better understand patients' viewpoints and beliefs about health, an awareness of the patient's cultural background was important. Open communication and showing patients love and respect were also highlighted as important components in PCC. Ultimately, the nurse is required to be accountable for her actions, as this directly relates to the outcomes of care received by patients. Further themes revealed that in order to enable PCC, a positive work environment, collaborative teamwork, continuous in-service as well as professional leadership contributed greatly. If people are happy to be at work, it will show in the work that they produce (Jardien-Baboo *et al.* 2016: 397-405). Jardien-Baboo *et al.* (2016: 397-405) further recommended that extra emphasis should be placed on nurse training programmes as well as in-service education to promote the use of PCC approach in the clinical setting. Furthermore, nurse managers should be aware of their leadership styles and how it impacts on the other staff as well as the patients (Jardien-Baboo *et al.* 2016: 397-405). Ensuring that information is shared with and explained at the level of patients' understanding is an important aspect in PCC, as being fully aware of their condition and treatment plan allows them to feel at ease (Rosen, Lynam, Carr, Reis, Ricca, Bazant and Bartlett 2015: 310).

Almaze and de Beer (2017: 59-65) reported that the promotion of therapeutic nurse-patient relationships is central to many health-related disciplines. Language barriers impacted greatly on the effective delivery of PCC. Patients became frustrated as language barriers prevented them from being understood by nurses and they also could not understand the instructions given by nurses. They concluded however that most nurses were encouraged to learn the primary language of the patient to promote understanding. Language barriers have been shown to be a huge threat to the quality of care produced (Van Rosse, de Bruijne, Suurmond, Essink-Bot and Wagner 2015: 1). Psychiatric nurses should be prepared and trained to engage in a higher level of respect and empathic understanding of mentally ill patients. Nurses are believed to be the backbone of the healthcare system and in turn are expected to be emotionally and skillfully equipped to provide holistic care. It is vital that nurses are aware of, and sensitive

to patients' physical and mental health challenges in a constantly changing healthcare environment (Van den Heever 2012: 71).

Evidence of PCC being implemented in the sub-Saharan African countries remains scarce. Outcomes on PCC related practices in African health centres have been reported to be more negative than positive (De Man, Mayega, Sarkar, Waweru Leys, Van Olmen and Criel 2016; Mulqueeny and Taylor 2017; Almaze and de Beer 2017).

2.4 GLOBAL VIEW OF PATIENT-CENTRED CARE

Globally, PCC is widely recognised by health care systems and organisations (Pelzang 2010; Cloninger, Zohar and Cloninger 2010; Greene, Tuzzio and Cherkin 2012; Lewis *et al.* 2016; Santana, Manalili, Jolley, Zelinsky, Quan and Lu 2018). It is believed that PCC is a crucial component in quality health care and is included in many mission and vision statements of health care institutions. PCC appears to be a part of the universal language when it comes to nursing and its values. It seems that PCC may sometimes be taken for granted as it is what health care workers aim to achieve. Due to the many challenges faced in the clinical setting, there seems to be a gap in the guidelines on the implementation of PCC (Brown, McWilliams and Ward-Griffin 2006; Bolster and Manias 2009; Ross, Tod and Clarke 2015; Santana *et al.* 2018). Previous studies revealed that PCC focused on the relationship between the patient and other members of the MDT (Greene, Tuzzio and Cherkin 2012: 49). Some researchers argue that PCC extends far beyond that of just the relationship between the patient and the MDT (Bolster and Manias 2009; Lund *et al.* 2011; Ross, Tod and Clarke 2015).

According to Pulvirenti, McMillan and Lawn (2011: 303-310), the global burden of chronic illnesses is growing at an alarming rate and the management of thereof needs to be addressed with great caution. It is recommended that careful planning is required to promote patients' taking charge of their health. Increased understanding of one's illness, treatment regime and prognosis is important to gain the patient's support in tailoring their road to health. A patient-centred approach is said to increase the individual's confidence in decision making regarding their health and well-being. It is believed that health care has evolved from a situation where the patient takes instructions about their health care from the MDT to an approach whereby the patient is fully involved in their treatment (Delaney 2018: 119). More importantly health care workers have come to realise that the care of a patient is a partnership between the various health care workers and the patient (Ekman, Wolf, Olsson, Taft, Dudas, Schaufelberger and Swedberg 2012: 1118).

Ekman *et al.* (2012) studied the effects of person-centred care in patients with chronic heart failure. Interventions were implemented as per the normal ward routine in the control ward during February 2008 and April 2009. This included the baseline assessment, care process mapping, discharge assessment; 3-month follow-up and a 6-month follow up. The person-centred care interventions were implemented during May 2009 and April 2010. The same process was followed, except that a person-centred care plan was initiated. This involved initiating a partnership, working the partnership and documentation. The findings suggested that when the PCC approach was implemented, it resulted in patients having a shorter hospital stay which improved their functional performance and reduced the risk for re-admission.

In Northern Ireland, McCormack and McCance (2006: 472-479) set out to develop a person-centred nursing framework. The framework comprised of four constructs; prerequisites which concentrated on the attributes of the nurse, the care environment which focused on the context in which the care is delivered, person-centred processes which looked at delivering care through a range of activities and lastly the expected outcomes which was the results of effective person-centred care. The attributes of the nurse played an important part in the implementation and the outcome of the framework. The specific attributes were related to professionalism, competency, interpersonal skills and being committed to their job. To provide effective care, the nurse needed to have interpersonal skills that allowed her to communicate at varying levels in the clinical setting. Other important aspects of the environment included effective staff relationships and the availability of adequate resources. Working with patients and the ability to understand and accommodate their belief and values systems reinforced the achievement of the outcome of a person-centred care. There must be a percentage of negotiation between the patient and the nurse in order to find some common ground on which they both agree. In this way the patient is fully accepting of their responsibilities as a patient, therefore open communication is a vital component in the nurse-patient relationship. McCormack and McCance (2006: 478) concluded that whilst there is an increasing empirical base for person-centred nursing, little research has been done to determine the outcomes for nurses and patients. Hence, the development of mid-range theories through critical analysis is vital in the future of person-centred care.

Bolster and Manias (2009: 154-165) conducted a study in a hospital setting in Melbourne, Australia. They explored how nurses and patients interacted with each other during medication activities. The researchers initially observed the medication rounds and interactions between nurses and patients. The analyses revealed that some results were not consistent with other studies related to PCC.

The level of experience and the time that the nurse was placed in that particular ward had no impact on the nurse's ability to provide effective PCC. In another study, lack of time was identified as a potentially inhibiting factor in the PCC approach (Epstein and Street 2011: 100). Some of the factors that contributed to the constraints in time were the workload in the ward as well as caring for the acutely ill patients. It has already been established that PCC is important to ensure the quality care of patients (Epstein and Street 2011: 100). It is essential for nurses to be fully aware of what exactly PCC entails, as this could be a reason why it is not being implemented as effectively (Epstein and Street 2011: 101). Epstein, Fiscella, Lesser and Stange (2010: 1489) supported the notion that PCC could possibly be misunderstood, which is why it is not being used to the nurses' and patients' advantage. If the MDT and the patients are in agreement with the health plan, improved care and well-being of patients will be achieved.

Several studies globally indicate that PCC is said to be very effective when used appropriately by mental health professionals who can make use of the variety of methods to develop the character and well-being of MHCUs (Cloninger, Zohar and Cloninger 2010; Van der Feltz-Cornelis 2011; Collins, Insel, Chockalingam, Daar and Maddox 2013; Theodoridou, Hengartner, Gairing, Jäger, Ketteler, Kawohl, Lauber and Rössler 2015). PCC has all the components necessary for ensuring that patients are nursed effectively and efficiently. Therapeutic relationships between the nurse and patients with mental disorders are an important skill required by a psychiatric nurse. A therapeutic nurse-patient relationship is the building block on which nursing practice and PCC are built (El-Salamony, Morsy, Shalaby and Sabra 2016: 59-70). One of the main goals of psychiatric nursing is to equip MHCUs with adequate coping and problem-solving skills to live a normalised life in the community. Effective psychosocial skills training promotes the development of improved functioning and supports effective rehabilitation in mentally ill persons (Sorour *et al.* 2014; Morin and Franck 2017).

2.5 COMPONENTS OF PATIENT-CENTRED CARE

Research shows that there are many components that impact on the implementation of PCC in the health care setting (Richards, Coulter and Wicks 2015; Rosen *et al.* 2015; Santana *et al.* 2018). Nursing is a very routine orientated profession, which over the years has been tailor-made to suit both patients and nurses. Once this routine has been established, it becomes second nature to nurses in the clinical setting. Nurses have been programmed to carry out duties routinely, yet they are also well equipped to deal with unexpected

situations in their daily busyness (Lützén 2015; Ulin *et al.* 2016). In saying this, it is believed that if PCC becomes a part of nurses' daily routine, this will be beneficial to both nurses and patients. Some common components have been identified to promote PCC in the clinical setting. Liberati, Gorli, Moja, Galuppo, Ripamonti and Scaratti (2015: 45-52) identified two broad categories that would possibly promote PCC, namely, PCC at the micro-level and PCC at the macro levels. Although they are separated into categories, both work hand in hand to ensure success. The micro-level focuses on the relationship between the patient and the nurse, while the macro-level includes the structural, cultural and procedural dimensions of health care facilities that are required to enable PCC to be achieved.

De Man *et al.* (2016: 162-173) further expanded on these concepts and suggested that the clinical encounter of nurses with patients included three distinct layers which interacted with each other, namely: (1) The nature of patient-provider interaction; (2) Features of the organisational and structural health systems and (3) Socio-cultural environment. These concepts are explained briefly below:

2.5.1 The nature of patient provider interaction

A significant aspect of the patient-provider interaction is the level of education and skills of the health care provider or nurse. In order to provide effective PCC, the appropriate training and educational support should be provided. This needs to be promoted in the clinical setting to effectively correlate the theory with practice. The use of standardised guidelines can sometimes promote a very rigid nurse-patient relationship. It is therefore critical that nurses are supported in following standard procedures as well as ensuring PCC is provided (De Man *et al.* 2016: 162-173).

2.5.2 Features of the organisational and structural health systems

The health system related constraints on PCC in sub-Saharan Africa corresponds to the weak status of structural health systems elements. These include a poor supply of qualified nurses and a weak information system. Overworked as well as underpaid nurses, result in a poorly rewarded and underqualified workforce. Further constraints that impact on PCC are a lack of essential equipment and medications and limited or inadequate workspace (De Man *et al.* 2016: 162-173).

2.5.3 Socio-cultural environment

The environment that is created by nurses and into which the patients are received creates the ambience for what comes next. In many African societies, the scene is set, whereby the nurse takes on the authoritarian position and the patient complies with direction provided by nurses. This type of socio-cultural environment does not promote PCC. Patients should feel free to discuss their concerns as well as be a part of their plan of care (De Man *et al.* 2016: 162-173).

2.6 SUMMARY OF THE CHAPTER

This chapter presented an overview of studies conducted in South Africa and globally and shows the similarities and differences in perceptions and understanding of the concept of PCC. It also provided literature on the integration of mental health care into PHC and mental health care in South Africa. The following chapter will explain the conceptual framework that guided this study. Concepts relating to this framework and its significance to this study will be highlighted.

CHAPTER 3: THEORETICAL FRAMEWORK

3.1 INTRODUCTION

This chapter discusses the conceptual framework that guided this study. According to Imenda (2014: 185-195), the terms conceptual and theoretical frameworks have often been used interchangeably. A theoretical framework refers to the theory that a researcher may use to guide the study. It is a set of concepts that are drawn from a theory to further explain the research study. Conversely, a conceptual framework relates to the outcome of several concepts put together to provide a better understanding of a phenomenon. Finally, both the theoretical and conceptual frameworks serve the same purpose, with differences remaining in their methodology and their application to a study.

3.2 CONCEPTUAL FRAMEWORK USED AS A GUIDE

The conceptual framework that guided this study is the Neuman's Systems Model. As early as the 1970s, Neuman began formulating her Systems Model. This model was initially developed to provide unity or a focal point for students in learning (Mommott, Marett, Bott and Duke 2017: 58-73).

3.2.1 The Neuman's Systems Model

This model is explained by Mommott *et al.* (2017: 58-73). It is viewed as a holistic approach that encourages members of the MDT to focus on health promotion, maintaining wellness, prevention and management of stressors that are recognised as determinants for ill-health. The Systems Model presents a nursing-based framework for individuals, families, and communities. The individual is viewed as an open system that may interact with the internal and external environment to maintain a balance. The application of this model is relevant in this study as it is directly related to the definition of mental health. According to WHO (2018:1) ,“mental health is a

state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". In order for PCC to be effectively used, members of the MDT in the community psychiatric setting should work together towards a common goal. In doing so, the MHCUs will be aware of the expectations when they visit the clinic. Neuman's Systems Model has also been proven beneficial when used with people with disabilities, as they find it difficult to effectively deal with the demands and frustrations of everyday living (Memmott *et al.* 2017: 58-73). The Neuman's Systems Model of client system is represented by a number of solid and broken circles. The major features are identified below:

3.2.2 The central circle: Basic structure

This is the basic structure or energy source, which includes survival factors such as genetic response patterns, strengths or weaknesses of body organs and normal temperature. The basic structure further consists of characteristics that are unique to a specific individual such as the artistic ability (Memmott *et al.* 2017: 58-73).

3.2.3 The outermost solid circle: Normal line of defense

This represents a person's normal state of wellness or the usual state of adaptation which they have developed over time. In this space, the person is able to function at an optimal level without the influence of stressors that may impact negatively on the individual (Memmott *et al.* 2017: 58-73).

3.2.4 The broken line outside the normal line of defence: Flexible line of defense

This relates to the flexible line of defence, whereby its ability to protect is diminished. This line would prevent the stressors from invading the client system by blocking stressors before they can attack the normal line of defense. The flexible line of defense is similar to the way an accordion works.

As the line expands, the protection is greater, when it narrows and gets closer to the normal line of defense; the ability to protect is diminished. Factors that impact on the line expanding are regular exercise, adequate nutrition and sufficient sleep, in other words, a well-balanced and healthy lifestyle (Memmott *et al.* 2017: 58-73).

3.2.5 Broken circles surrounding the basic structure: Lines of resistance

These lines refer to the reactions that occur in the client's system when a stressor is able to penetrate the normal line of defense. These lines are meant to restore equilibrium and protect the basic structure, for example as soldiers would protect the perimeter of a castle (Memmott *et al.* 2017: 58-73).

3.3 COMPONENTS THAT INTERACT WITH THE CLIENT SYSTEM

There are five variables that have been listed which are seen to overlap and influence all functions of the client systems. Responses of the client systems should be viewed in the contexts of these variables; physiological, psychological, sociological, spiritual and developmental. Clients are subjected to three types of stressors:

- Intrapersonal: Conditioned responses that occur within the individual.
- Interpersonal: These responses occur between the individual and others.
- Extra personal: These relate to the forces that occur as a result of the wider environment or culture in which the client lives (Memmott *et al.* 2017: 58-73).

Stress impacts greatly on an individual, both physically and emotionally. Physical symptoms such as headaches and chest pain are common but could also result in anxiety and sadness. Furthermore, chronic stress could increase the risk of mental illness (Yaribeygi, Panahi, Sahraei, Johnston and Sahebkar 2017: 1057-1072). The Neuman's Systems Model therefore directly relates to MHCUs living in the community. Due to their illness, many receive a disability

grant as they are unfit to work. These problems increase their stress levels; poverty, unemployment and stigma all contribute to the levels of stress that MHCUs experience. Below is a diagrammatic presentation of the Neuman's Systems Model (Figure 3.1).

In PCC, the patient is nursed holistically, considering their physical, psychological as well as their social well-being. The Neuman's Systems Model could be effectively adapted to PCC whereby primary, secondary as well as tertiary prevention is considered when nursing patients in the community.

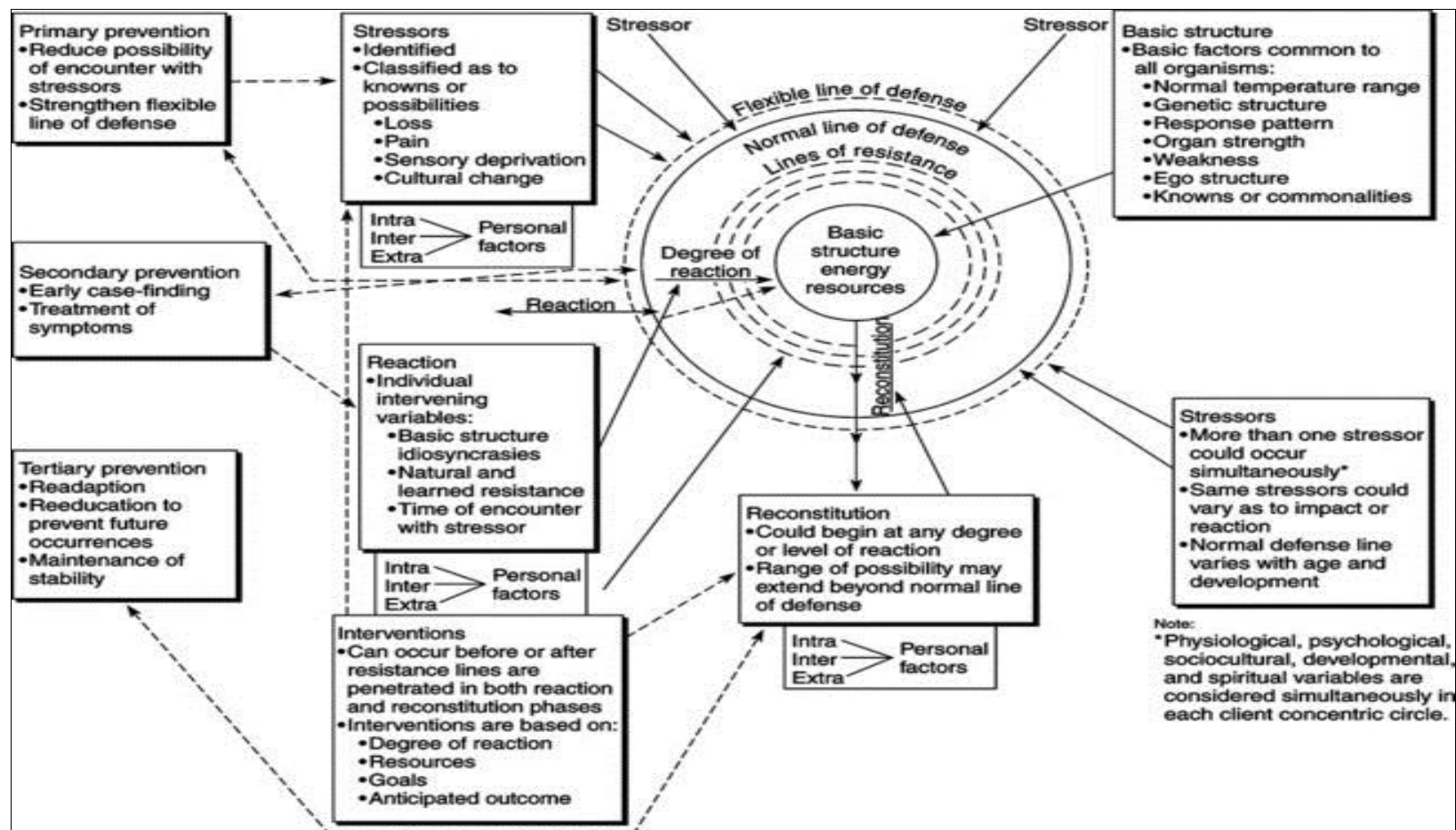


Figure 3.1: Neuman's Systems Model (Neuman and Fawcett 2011: 3-36)

3.4 SUMMARY OF THE CHAPTER

In this chapter, the conceptual model that guided this research study and its relevance was explained. The next chapter explains the research methodology that the researcher used as well as the setting and the target population. The data collection process, analysis and ethical considerations in this study are also described.

CHAPTER 4: RESEARCH DESIGN AND METHODOLOGY

4.1 INTRODUCTION

This chapter focuses on the research design and methodology that was undertaken in this study. The three phases of data collection are also discussed.

4.2 RESEARCH DESIGN

According to Grove, Burns and Gray (2013: 195), a research design is a detailed plan according to which the research is conducted. The research design articulates what data are required, what methods are going to be utilised to collect and analyse data and how this will answer the research questions. The choice of the research design is dependent on the purpose of the research. The researcher used a mixed-methods approach in the current study. According to Graff (2016: 51), mixed methods research provides a practical approach to addressing research problems and questions. In mixed-methods studies, researchers use a combination of qualitative and quantitative designs to achieve the objectives of a study (Creswell 2014: 44). This combination of qualitative and quantitative methods can be conducted concurrently (parallel) or sequentially. This study was guided by a convergent parallel mixed-methods design, sometimes also referred to as concurrent triangulation design.

4.2.1 Convergent parallel mixed- methods design

The convergent parallel mixed-methods design allows the researcher to develop an in-depth understanding of the research problem at hand, whereby the researcher can obtain both quantitative and qualitative data. The purpose of combining both methods together yields a more complete analysis of the data (Creswell 2009: 7). Creswell (2014: 44) further explains that convergent mixed - methods design allows the researcher to collect both forms of data at

more or less the same time and then integrate the information of the overall results. As a result, contradictions or incongruent findings are explained or further probed for clarity. In addition, the use of triangulation may assist with the combining of qualitative and quantitative findings which helps researchers with the interpretation of the results. The improved understanding between theory and empirical evidence challenge theoretical assumptions and allows new theories to be developed (Caruth 2013: 112-122). Morgan (2007: 48-76) stated that the distinct difference of key features between qualitative and quantitative research is the process of induction and deduction. The inductive results produced in a qualitative approach can be used to add value to the deductive goals of a quantitative approach and vice versa. Creswell (2009: 7-10) provides a brief explanation of the process of the convergent parallel design which is illustrated further in Figure 4.1.

- Data collection: Quantitative or qualitative results build to the subsequent collection of qualitative or quantitative data.
- Data analysis: Transforms one type of data into other types of data and analyses the combined data.
- Interpretation: Comparing or combining the results from both methods.

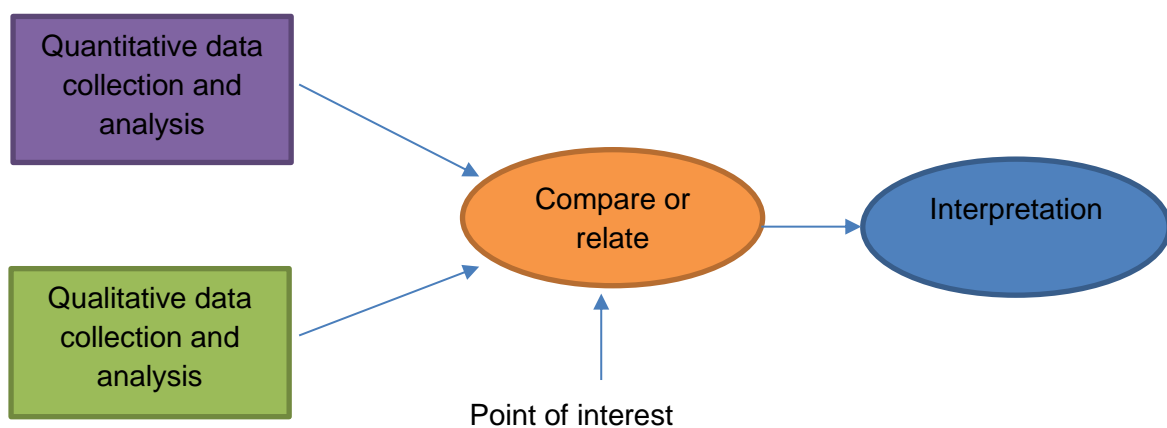


Figure 4.1: Convergent parallel mixed methods design (Creswell 2009: 208)

4.3 RESEARCH PARADIGM

Polit and Beck (2010: 14-18) describe a paradigm as a world view and a general perspective on the complexities of the real world. They further emphasise that paradigms are lenses that redirect the focus on the phenomena of interest. Paradigms can be used as a guide to ground one's research study and can also assist the novice researcher to align their choices with their values (Shannon-Baker 2016: 321). Various paradigms may be used to guide research studies (Polit and Beck 2010; Shannon-Baker 2016). According to Shannon-Baker (2016: 322), four paradigmatic perspectives are applicable in mixed methods research; namely pragmatism, transformative-emancipation, dialectics and critical realism. The researcher used the pragmatist paradigm to guide this study. The use of the pragmatist paradigm in mixed - methods research has been proven to be a useful tool (Feilzer 2010: 6-16). Pragmatism can be both contextual and generalisable by analysing them for transferability to another similar situation (Shannon-Baker 2016: 322). According to Kivunja and Kuyini (2017: 26-41), a paradigm consists of four elements, namely epistemology, ontology, methodology and axiology which will be briefly discussed below.

4.3.1 Epistemology of a paradigm

The word epistemology is derived from the Greek word 'episteme' which translates to 'knowledge'. Epistemology in research is used to describe how we have come to the conclusion of truth or reality. If one relies on knowledge such as beliefs, faith and intuition, then the research is based on intuitive knowledge. Information obtained from people, books and leaders in organisations is referred to as grounded or authoritative knowledge. Empirical epistemology is based on sense experience as well as objective facts (Kivunja and Kuyini 2017: 26-27). In this study, the researcher extrapolated existing knowledge on the provision of mental health care in South Africa.

4.3.2 Ontology of a paradigm

Ontology is based on the philosophical study of the nature of existence or reality. It examines the researcher's underlying beliefs about the nature of being and existence. The philosophical assumptions of the researcher are vital in how the researcher makes sense of data obtained and the meaning of such results. The assumptions made by the researcher help to format ones thinking about the research problem and its significance (Kivunja and Kuyini 2017: 27). It is a reality that in South Africa, due to their illness, PLWMDs are vulnerable.

4.3.3 Methodology of a paradigm

Methodology refers to the logic, flow or direction of the systematic processes that are followed in conducting a research study. Taking into consideration the methodology of one's research study, the researcher should reflect and question oneself about how the knowledge, understanding and relevant data related to the research problem and questions will be collected (Kivunja and Kuyini 2017: 26-28). The researcher developed questions to collect data and thereafter, analysed and compiled a report that assisted in the development of the guidelines.

4.3.4 Axiology of a paradigm

Axiology encompasses the ethical considerations when planning a research study. The researcher is required to evaluate the ethical and moral issues related to their study. It is important to take into consideration the human values of the participants in the research. Ways to avoid or minimise physical, psychological, legal, social, economic risk or harm are considered (Kivunja and Kuyini 2017: 26-28). All principles of ethics were considered during the course of the study.

4.4 SETTING

According to Polit and Beck (2010: 130), the research setting is the physical location in which data collection takes place. Creswell (2014: 173) further indicates that researchers intentionally select sites to obtain the necessary and required information. Therefore, the researchers should select the settings that will provide relevant information. The current study took place in the Pietermaritzburg (PMB) area. PMB is the capital city of the Province of KZN and is also the second largest city in KZN. The Province of KZN has the second largest population of approximately 11.4 million people with the total population in PMB estimated at 618 536 people (Statistics South Africa 2018). The study was conducted at three Community Health Centres (CHCs) and three Provincial PHC clinics that offer specialised psychiatric services within the uMgungundlovu district. The CHCs in this study are referred to as CHC 1, CHC 2 and CHC 3. The PHCs are referred to as PHC 1, PHC 2 and PHC 3.

Provincial clinics provide services to the respective catchment areas in a province. PHC services are provided by professional nurses and additional services are provided by doctors or other specialists; namely ophthalmologists and occupational therapists. Services are usually offered over an eight-hour period and the more complex cases are referred to the nearest district hospital. A CHC is the second step in the provision of health care but can also be used for first contact care. A CHC offers similar services to a Provincial clinic with the addition of a 24-hour maternity service, emergency care, casualty and a short stay ward. The CHC will refer a patient to a district hospital when necessary (KZN Department of Health 2019: 1). The researcher's place of work was used as a central region to calculate the distances to the CHCs and PHC clinics in which the research study was conducted. The distances measured in kilometres (km) are illustrated in Table 4.1.

Table 4.1: Distances to the research facilities

Psychiatric Facility	Distance from place of work
CHC 1	6.5 km
CHC 2	16.3 km
CHC 3	65.5 km
PHC 1	12.8 km
PHC 2	8.9 km
PHC 3	9.2 km

4.5 SAMPLING PROCESS

A sample is defined as a subset or portion of a particular population which has been identified for the intended study (Botma *et al.* 2010: 124). Polit and Beck (2010: 307) explain that the process of sampling is achieved by obtaining specific subjects from a specific population that is relevant to the study. According to Graff (2016: 54), probability sampling is most often used in quantitative research to obtain a sample that represents the chosen population. Conversely, purposeful sampling techniques are generally used in qualitative research. Mixed- methods research makes use of both purposeful and probability sampling techniques. The researcher used purposeful sampling in the current study. Most importantly; the characteristics of the sample should represent the population (Polit and Beck 2010: 310).

The target population in this study was professional nurses who were in direct contact with the MHCUs and the operational managers in the CHCs and PHC clinics that offered a psychiatric service. All nurses belonging to these categories had an equal opportunity to participate in the research study. The researcher personally contacted each clinic and CHC to determine the number of professional nurses who were in direct contact with MHCUs on a daily basis. Each clinic was managed by one operational manager who was overall in charge of the department, with nurses of other categories that assisted. One or more relief psychiatric professional nurses were placed to

cover the clinic if the allocated psychiatric professional nurse was not available. Therefore, in total there were twelve professional nurses who relieved each other and six operational managers who managed the facilities, resulting in a total sample of 18 participants. A total of 15 participants consented to being a part of the study. The professional nurses remained in the psychiatric clinic for a period that ranged between 6-12 months. For the quantitative part of the study, using an alpha level of .05 and a margin of error of .05; all fifteen nurses were included in the sample.

Polit and Beck (2010: 321) state that in qualitative research there are no rules that dictate the sample size as generally the sample size is related to the informational needs. Therefore, in qualitative research methodology, researchers are guided by the principle of data saturation. Data saturation is when no new information is being generated by the participants and redundancy is achieved. In the current study, the researcher continued collecting data until saturation of data was achieved. Data saturation was reached with the 13th participant, although the researcher continued interviews with all 15 participants who consented as participants were eager to share their views.

4.5.1 Inclusion criteria

- Operational managers overall in charge of the clinic.
- Professional nurses who were in direct contact with MHCUs daily.

4.5.2 Exclusion criteria

- Professional nurses who were not in direct contact with MHCUs daily.
- Enrolled nurses.
- Enrolled nursing assistants.
- Support service officers.

4.6 DATA COLLECTION PROCESS

Data collection is a process of collecting information from a certain population to find answers to the research problem (Bryman 2016: 12). Brink, Van der Walt and Van Rensburg (2012: 201) refer to data as pieces of information or facts obtained during a study. According to Doyle, Brady and Byrne (2016: 623-635), the use of convergent or triangulation designs allow for equal importance to be given to both quantitative and qualitative data whereby the results are thereafter merged during the interpretation phase. It is believed to be an efficient research design, as the researcher is able to collect the data at more or less the same time, ensuring that the population remains accessible. In the current study, data was collected through three distinct phases, namely; Phase 1: observation, Phase 2: survey and Phase 3: one –on- one interviews. In mixed - methods research, data is collected through open-ended or semi-structured interviews as well as field observations of practices (Creswell 2009: 7-12). The researcher began with the observation phase 1, then completed phase 2 which was the quantitative survey phase and lastly the qualitative phase whereby the researcher conducted one –on- one interviews. Analysis of data commenced after each phase. Results of phases 2 and 3 were then converged to compare and relate the data obtained. Thereafter an accurate account of the data was interpreted.

The researcher approached all potential, willing participants and distributed information letters regarding the survey (Appendix 5a) and the one- on- one interview process (Appendix 5b). The researcher was available to clarify any misconceptions and answer all queries regarding participation in the study as well as the data collection process. Thereafter informed consent was obtained; the participants were not required to reveal their names as each consent form was coded to ensure anonymity. In totality, Phases 2 and 3 lasted for about 40 minutes for each participant.

4.6.1 Phase 1: Observation

Phase 1 entailed directly observing the daily processes of the psychiatric facility. Observations were chosen as the method of gathering data because it is an ideal method for gathering data on non-verbal behaviour and it allows the researcher to achieve the most objective experience of the community. Data is gathered directly and is not of a retrospective nature (De Vos, Strydom, Fouche and Delport 2011: 338). A structured (closed-ended) observation checklist was used to collect data. Structured observations assist the researcher to focus on specific predetermined areas and aspects (De Vos *et al.* 2011: 338). A structured observation checklist (Appendix 7) was used to observe the daily processes of the clinics and CHCs. Additional observations included the infrastructure, staffing, supplies, administrative processes followed and waiting times.

Additional field notes were documented to provide a clear picture of the observations. De Vos *et al.* (2011: 329) identify two types of observation, namely disguised (non-participant) and undisguised (participant) observation. The researcher used undisguised (participant) observation. However, to minimise the Hawthorne effect, the researcher spent the first two days in the PHC clinics and CHCs so that the participants were used to her presence (Polit and Beck 2010: 264). Being at the study sites for the first two days before commencing the observation provided an opportunity for the researcher to familiarise herself with the surroundings. During this period, the researcher provided information sessions and identified focus points to conduct observations. The researcher thereafter remained in the observation sites for longer by spending a minimum of one week in each clinic that was included in the sample.

4.6.2 Phase 2: Survey

A survey was conducted through utilising a structured questionnaire. A survey can be done to measure an event, attitude or behaviour in a specific population. At a specific point in time, the information is collected from a

sample of the target population group through a descriptive survey. In the survey, the participants are asked to report events, feelings and behaviours retrospectively (Bowling 2009: 215). Once written consent was obtained, the participants were requested to complete a short questionnaire consisting of closed - ended questions (Appendix 8). Section A included the demographic data. Section B included aspects of PCC as well as the participant's perceived barriers to PCC. The questionnaire took participants approximately 5-10 minutes to complete. A sealed box was provided to the participants to deposit the completed questionnaire.

4.6.3 Phase 3: One-on-one interview

One-on-one, face-to-face interviews were conducted. An in-depth interview is a one-to-one method of data collection that involves an interviewer and an interviewee discussing specific topics in depth. In-depth interviews are used when seeking information on individual, personal experiences from people about a specific issue (Hennink, Hutter and Bailey 2011: 109).

An interview guide (Appendix 9b) was used to ensure the consistency of questions during the interview process. An interview guide is a list of questions used by the interviewer, mainly as a guide or memory aide during the interview (Hennink, Hutter and Bailey 2011: 112). The interview guide included demographic data in Section A (Appendix 9a) and the following research questions were asked in Section B:

- What strategies are used to implement PCC for MHCUs?
- To what extent has mental health been integrated into PHC?
- What changes would you propose in order to enhance PCC for MHCUs?
- Based on the participants' responses, probing questions were asked to further understand their explanations.

Prior arrangements were made with the person in charge to conduct interviews and appropriate dates and times were arranged. Permission was sought from the participants for the use of an audio recorder to capture conversations verbatim to ensure trustworthiness of the data collected. The researcher also replayed the recorded interviews to reflect with the participants and clarify any misconceptions or misinterpretations. Interviews were conducted in a quiet room at a time specified by the participants to prevent any disruption in their daily routine. It took approximately 20-30 minutes to complete the interview process. Interviews continued until all the consenting participants were interviewed.

4.7 PRE-TESTING OF THE DATA COLLECTION TOOLS

A pretest is a process of trialing the data collection tool to assess its usefulness in yielding desired information (Polit and Beck 2010: 345). Conducting a pilot study enables the researcher to evaluate each step of the research process. Suggested adjustments could be made to improve the quality of the study (Watson, McKenna, Cowman and Keady 2008:183). Furthermore, a small-scale pilot study can also assess the feasibility of such a study and determine whether the field workers possess the appropriate skills to carry out the study (Botma *et al.* 2010: 275).

In the current study, the researcher carried out a pre-test in the outpatients' department (OPD) among professional nurses who attend to MHCUs that are in the community. This psychiatric OPD was not a part of the final study as it was attached to a specialised tertiary hospital; it is not classified as a stand-alone community psychiatric clinic. Two professional nurses were purposively selected to participate in the pre-test. The researcher conducted the pre-test with the participants to obtain feedback and to determine if the research questions and methods were feasible. No changes were made as the participants reportedly found the questionnaire and research questions to be clear and understandable.

4.8 DATA ANALYSIS

Data analysis is the manner that decreases, organises and gives meaning to data (Creswell 2009: 185). Graff (2016: 59-61) explains that in mixed - methods data analysis, the researcher requires knowledge of strategies used in qualitative and quantitative data. In addition, Grove, Burns and Gray (2013: 46) further explain that data analysis involves the reduction, organising and ways of providing meaningful explanations of the collected data. The analysis of quantitative data involves the use of descriptive analysis techniques, to represent the data graphically as well as inferential analysis to explore trends in the data.

4.8.1 Qualitative data analysis

Qualitative data analysis involves an inductive process in which the researcher works towards addressing the research questions. The most commonly used method used in qualitative research is thematic content analysis, whereby the content of the data is coded and analysed until themes emerge. Creswell (2009: 185-190) suggests the blending of general steps of data analysis with the specific research strategy steps. This method has a linear, hierarchical and interactive approach. The steps are interrelated although they are not always approached in the same order.

Step 1: Organise and prepare

In this step the researcher organises and prepares the data for analysis. The interviews are transcribed; field notes are organised and typed out.

Step 2: Develop a general sense

The researcher should read through all the data, obtaining a general sense of the information and understand its meaning. Notes are written on their interpretation and meaning.

Step 3: Code the data

Coding is the process of organising the data into sections of text before attaching meaning to it. The researcher will take text data, phrases or words into categories and label those categories.

Step 4: Describe and identify themes

The coding process is used to generate a description of the setting or people. The themes refer to the major findings and are then used to create headings for reporting of findings.

Step 5: Represent findings

The most popular way of representing the findings is to use a narrative passage to explain the findings of the analysis. This will include a detailed discussion of several themes.

Step 6: Interpret the findings

This is a personal interpretation of the research findings together with supporting literature and or theories. The researcher could also suggest new questions that need to be asked to further clarify the study.

4.8.2 Quantitative data analysis

The analysis was carried out by using Version 25 of the Statistical Package for Social Sciences (SPSS) software. Descriptive statistics, in the form of tables and graphs, were to describe the data graphically. Descriptive statistics were used to summarise and describe the data collected. Descriptive statistics are most commonly used to describe the sample with regards to demographic data to allow the researcher to be able to generalise the findings to an entire population. Secondly, descriptive statistics were used to describe the characteristics of the data collected (LoBiondo-Wood and Haber 2010: 310). Averages and percentages were used to describe the characteristics of the data that was collected.

To test for significant trends in the data, inferential statistics were applied. These included Pearson's correlation, t-tests, ANOVA and chi-square tests. Inferential statistics can also be used to draw conclusions (LoBiondo-Wood and Haber 2010: 310). Inferential statistics were used to draw conclusions about components viewed as essential in the successful delivery of PCC for MHCUs as well as barriers impacting on the successful delivery of PCC for MHCUs. Hence this enabled the researcher to develop guidelines to enhance PCC for MHCUs in community psychiatric clinics. Non-parametric equivalent tests or exact tests were used for where the conditions were not met for the application of these tests, where applicable, was used. Throughout, a p-value of 0.05 was used to indicate significance. Further, the validity of results depended on the correct and appropriate use of statistical tests such that assumptions are not violated.

4.9 TRUSTWORTHINESS OF THE QUALITATIVE PHASE

To ensure a high quality of qualitative research outcomes, trustworthiness has to be maintained. Criteria to ensure trustworthiness were developed by Lincoln and Guba. According to Lincoln and Guba's Framework, four criteria are important in developing the trustworthiness of a qualitative study, namely credibility, transferability, dependability and confirmability (Polit and Beck 2010: 492-493). The researcher applied these criteria to ensure trustworthiness of the study. Brief explanations of the criteria are provided below.

4.9.1 Credibility

Credibility is viewed as confidence in the truth of the gathered data and the interpretations of the findings (Polit and Beck 2010: 492-493). It involves two main aspects; the study should be carried out in a way that promotes the authenticity of the findings and the various steps that are taken to demonstrate credibility to the external readers. The researcher ensured that field notes and memos were retained as collateral of information observed. An audio recorder was also used to record interviews between the participants

and the researcher to capture the true sense of the interview. The researcher replayed the recordings for the participants when necessary to ensure the credibility of the data.

4.9.2 Transferability

Transferability is the ability to show that the findings are applicable in other contexts, settings or groups (Polit and Beck 2010: 492-493). It is the responsibility of the researcher to provide sufficient descriptive data so that the consumers are able to apply the data to other contexts. The researcher used purposeful sampling of the specific target population as this ensured that the data obtained will be relevant and truthful to the study at hand.

4.9.3 Dependability

Dependability refers to the extent that the findings are consistent and could be repeated over time and with varying conditions (Polit and Beck 2010: 492-493). It questions the possibility that the same results would be obtained if the study was replicated in a similar context. A pre-test was conducted to evaluate whether the research questions are clearly understood and relevant to obtain accurate information. The researcher made necessary changes to the data collection process to enhance the dependability of the study.

4.9.4 Confirmability

Confirmability refers to the degree of neutrality or the extent to which the findings of a study are shaped by the participants and not researcher bias, motivation or interest (Polit and Beck 2010: 492-493). As stated previously, the researcher used an audio recorder to record the interviews verbatim. The researcher was able to replay parts of or if time permitted, the entire interview to verify or clarify any misconceptions or misinterpretations of what was said. In doing so, the participants were assured that the data received was unbiased and a true reflection of the interview.

4.10 RESEARCH RIGOUR OF THE QUANTITATIVE PHASE

Grove, Burns and Gray (2013: 36) define rigour as the striving for excellence in a research study whereby discipline, accuracy and detail are maintained. Validity and reliability were used to ensure rigour for the quantitative phases. Ensuring that validity and reliability is adhered to allows the researcher to generalise the outcome or results to similar situations (Welman, Kruger and Mitchell 2005: 145).

4.10.1 Validity

Validity is defined as the extent to which the findings of a study accurately represent the chosen study population (Welman, Kruger and Mitchell 2005: 142). According to Creswell (2014: 223), many threats may influence the validity of a study. Types of threats include internal validity threats and external validity threats.

Internal validity threats affect the ability of the researcher to draw accurate inferences from the data about the chosen population. There are threats that involve the participants, the experimental treatments that a researcher manipulates and those that are related to the testing and instrumentation that may be used in the research study (Welman, Kruger and Mitchell 2005: 142). To ensure internal validity in the current study, the researcher used an audio recorder to ensure that the participants' responses were recorded verbatim. This reduced the margin of error, whereby the researcher could replay the responses and accurately document them. This eliminated any bias and possible misinterpretation of results.

External validity threats may surface when the data collection instrument draws on incorrect inferences from the sample data to other persons, settings, past or future situations. Welman, Kruger and Mitchell (2005: 142) further state that construct validity refers to an instrument used in a study measuring what it is intended to measure. A pretest was conducted in a setting similar to that of the actual research setting in the current study. To ensure that the

research instrument was user- friendly and the research questions were in line with the objectives of the study, the results were analysed for relevance and accuracy.

4.10.2 Reliability

Reliability refers to the findings of the research and the credibility of such findings. This implies that if anyone else were to repeat the study, they would obtain the same results as was previously found (Welman, Kruger and Mitchell 2005: 145). In the current study, the researcher conducted a pretest to ensure that the data collection instrument yields accurate results. The researcher analysed the results of the pretest to assess if the data collection tool is addressing the core problems. Proposed changes to the tool were made to ensure validity and reliability of the results.

4.11 ETHICAL CONSIDERATIONS

Ethical behaviour in research is of vital importance. In most cases, the principles underlying research ethics are universal in biological, social and health sciences (Welman, Kruger and Mitchell 2005: 181). Botma *et al.* (2010: 277) further declare that to ensure ethical principles are maintained, the researcher should be competent to conduct the research study. A discussion of the ethical principles followed in the study is discussed below.

4.11.1 Permission to conduct the study

The researcher sought ethical approval from the Institutional Research Ethics Committee (IREC) of the DUT (Appendix 1). Permission was also sought and granted by the District Managers (Appendices 2a and 2b), KZN Department of Health (Appendices 3a and 3b) and the Managers of selected clinics (Appendices 4a and 4b).

4.11.2 Informed consent

The researcher ensured that adequate time was allocated to address the participants prior to them consenting to be a part of the study. An information letter explaining the process of data collection as well as a brief overview of the study was discussed (Appendices 5a and 5b). Prospective participants were given the opportunity to ask questions, free of discrimination or judgment. Participants were requested to sign an informed consent once they had decided to willingly participate in the study (Appendix 6). They were however free to withdraw at any stage in the study and was not in any way intimidated or coerced into remaining in the study. It is important to obtain consent from the participants after factual information about the study has been shared with them (Welman, Kruger and Mitchell 2005: 201).

4.11.3 Protection from harm

Participants should be informed that they will be protected against any forms of physical and emotional harm (Welman, Kruger and Mitchell 2005: 201). When people are approached to be a part of a study, it should be clear from the onset that they do not suffer any disadvantage or harm when they are participants in the study (Flick 2007: 73). Brink, Van der Walt and Van Rensburg (2008: 32) emphasise that respondents have a right to be protected from discomfort and all forms of harm, namely physical, emotional, spiritual, economic, social or legal. In the current study, the researcher ensured that the well-being of the participants was always protected. Participants were not subjected to any situation where they were in harm's way. Participants were not exposed to any invasive procedures. Participation was voluntary and they were at no stage pressured or coerced into participating in the study. Participants were free to withdraw from the study at any time without any repercussions.

4.11.4 Confidentiality

It is the researcher's responsibility to ensure that confidentiality is always maintained throughout the study. Data collected in the forms of questionnaires, videos, audio recordings, interviews and transcripts should be stored in a secure place, accessible to the researcher only (Brink, Van der Walt and Van Rensburg 2008: 35). The participants in the current study were required to sign informed consent. The privacy of parts of, or all personal information requested of participants, were maintained. For the sake of confidentiality, the data capturing sheets were coded. Access to confidential information was limited only to the researcher. All recordings and data collected were locked in a cupboard which was accessible only to the researcher.

4.11.5 Justice

The principle of justice includes the right to a fair selection and treatment during the study. Participants should be selected with fairness and chosen as a result of being directly related to the study problem and not because they are available (Brink, Van der Walt and Van Rensburg 2008: 33). In the current study, the researcher ensured that all participants were treated fairly and with respect. The participants were informed at all times of any changes proposed or made and the researcher ensured that a new consent form was signed to incorporate changes. The researcher explained the implications of their participation in the study so that they are well informed and felt comfortable. All participants who met the inclusion criteria were given an equal opportunity to participate in the study.

4.12 SUMMARY OF THE CHAPTER

This chapter described the research methodology that was undertaken by the researcher. The ethical considerations that were relevant to this study were also explained. The following chapter 5 will present phase one (observation) of the findings of the study.

CHAPTER 5: PRESENTATION OF FINDINGS: PHASE 1 (OBSERVATION)

5.1 INTRODUCTION

The previous chapter presented the research methodology that was undertaken in this study, which included the three phases of data collection, namely: phase one – observation, phase two – survey questionnaire and phase three – one -on -one interviews. In this chapter, the findings that were obtained during the observation phase will be presented. An observational checklist was used to document data collected during this phase.

5.2 PRESENTATION OF FINDINGS

An average of one week was spent at each of the six facilities enabling the researcher to familiarise herself with the surroundings and processes carried out daily. This allowed the staff in these areas to become familiar and comfortable with having the researcher around. The staff continued with their daily duties naturally so a true picture of the clinical setting could be observed. The observation checklist comprised of seven main areas that were relevant to PCC in the community psychiatric setting namely:

- (1) Infrastructure.
- (2) Staffing.
- (3) Medicines and supplies.
- (4) Administrative processes.
- (5) Waiting times.
- (6) Patients directed to appropriate services.
- (7) Batho Pele principles.

The provision for comments was added after each main area to capture any other points of importance and to further explain the main areas above.

5.3 INFRASTRUCTURE

On observation of the physical condition of the clinical facilities, three of the facilities were in a poor condition and three were in a good condition. The areas were also assessed to determine if there was adequate space to provide an efficient service to the MHCUs who attended the clinic. Three facilities had unacceptable working spaces, two had fair spaces and one facility had good space. The essential equipment required for the day to day running of the services was also assessed. Analysis showed that 16.7% (n=1) had poor equipment, 50.0% (n=3) had fair equipment and 33.3% (n=2) had good essential equipment. The use of communication and information tools were found to have been used fairly in three of the facilities and good use was observed in the other three facilities.

To further explain the above observations, the researcher documented the following comments:

- PHC 1: The outdoor waiting area had good ventilation which has the potential to be hot or cold depending on the weather. Patients sit on wooden benches and plastic chairs.
- PHC 2: The indoor waiting area had plastic chairs and adequate ventilation.
- PHC 3: There is one waiting room for all patients and patients sit closely to each other. It does become very hot as ceiling fans are not very effective.
- CHC 1: The waiting area was very small and clustered. Ventilation is poor and patients sit indoors in a narrow passage on plastic chairs and wooden benches.
- CHC 2: There is one room allocated to MHCUs. The waiting area is indoors, well ventilated and spacious.
- CHC 3: There is one room allocated to psychiatry which is also sometimes used by the visiting doctor. Figure 5.1 illustrates the results of the infrastructure.

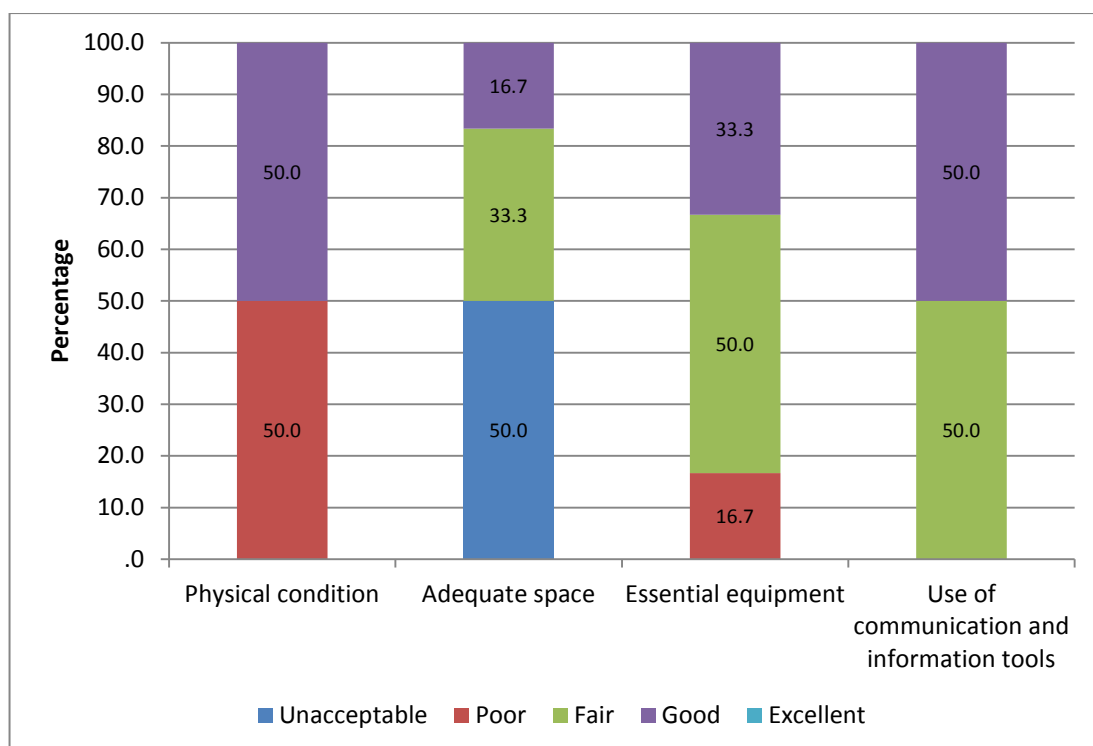


Figure 5.1: Observation of the infrastructure

5.4 ADEQUATE STAFFING

It was observed that there was usually one professional nurse working in the psychiatric clinic who consulted with patients for the day. The professional nurses were observed to work at a continuous pace, often having only a 10-minute break for tea and missing their lunch breaks to attend to the long queues of patients. It was observed that patients became restless while waiting or they would leave without being seen to.

5.5 ADEQUATE MEDICINES AND SUPPLIES

It was observed that 66.7% (n=4) of the facilities received their medication timeously. This was evident by the observation that patients left with their medication in hand after they had seen the professional nurse. At 33.0% (n=2) of the facilities, it was observed that patients became very agitated and some shouted and cried. This was due to them waiting for many hours, only to discover that once they went in to see the nurse, their medication had not

arrived at the facility or their medication was out of stock. MHCUs were visibly upset and communicated this to other patients who were still in the queue waiting to see the professional nurse.

5.6 ADMINISTRATIVE PROCESSES

Administrative processes were observed paying specific attention to adherence to the relevant policies, protocols, guidelines, accurate record keeping, safekeeping and control of patient documents. It was observed that policies and procedures, in English and isiZulu, were pinned up on the notice boards for patients to read. Pamphlets of the Patient's Rights Charter as well as the Rights of the Mentally Ill were placed at strategic points in the clinical setting. The safekeeping and control of documents was 100% (n=6). Lockable cupboards were used for patient information and documentation files. The windows had security bars and the doors had security gates.

Details of patient findings were recorded in a book as opposed to a file with loose pages. As each patient arrived at the clinic, their details were entered into the 'tick book' as well as the bookings book. Patients were issued appointment cards as a reminder of their next appointment date. Medication cards were kept separately to facilitate easy ordering and monitoring of medication. Figure 5.2 illustrates the administrative processes.

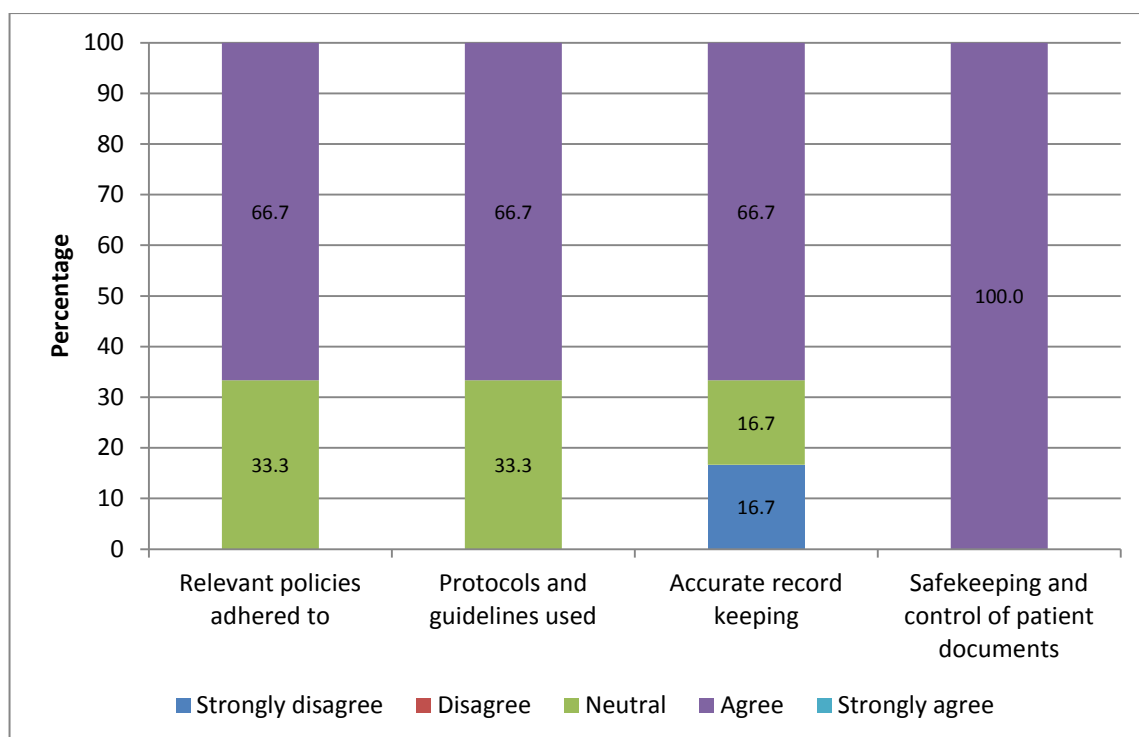


Figure 5.2: Administrative processes

5.7 WAITING TIMES

It was observed that for most of the times, patients waited no longer than 30 minutes to be seen by a nurse or a doctor. Initially, the MHCUs waited in the general queue to be screened. Once they were screened, they were sent to the relevant clinic where they joined another queue and waited once again. In other cases, patients who had missed their appointments or arrived on an incorrect day, had to wait until all the booked cases were attended to before they were seen. It was observed that these patients were given this information when they arrived at the bookings table.

5.8 PATIENTS DIRECTED TO APPROPRIATE SERVICES

It was observed that 66.7% (n=4) of times MHCUs were often directed to appropriate services. A further observation was that 33.3% (n=2) of times, direction to appropriate services was not possible due to challenges experienced with logistics of transportation and patients' temperament. Some

of the services that MHCUs were referred to include the social worker, audiologist, occupational therapist, the medical doctor if needed or a district hospital. The latter 33.3%, was as a result of challenges experienced with the referral of MHCUs to the nearest district hospitals for the 72-hour observation. If the patient was aggressive, they were transported by the ambulance services or the South African Police Services. This delayed the continuity of care for the patient who had to be sedated to be transported.

5.9 BATHO PELE PRINCIPLES

The adherence of the following Batho Pele Principles were assessed with the following results: Consultation - 66.7% (n=4); Service standards - 50.0% (n=3); Access- 66.7% (n=4); Courtesy- 66.7% (n=4); Information- 66.7% (n=4); Openness and transparency - 50.0% (n=3); Redress, Encouraging innovation, Customer impact and leadership and direction were sometimes adhered to at 50.0% (n=3) of the time. It was also observed that due to the busyness of some facilities, the Batho Pele Principles were not always followed. One of the waiting rooms displayed the Batho Pele Principles on the wall. The results are presented in Figure 5.3.

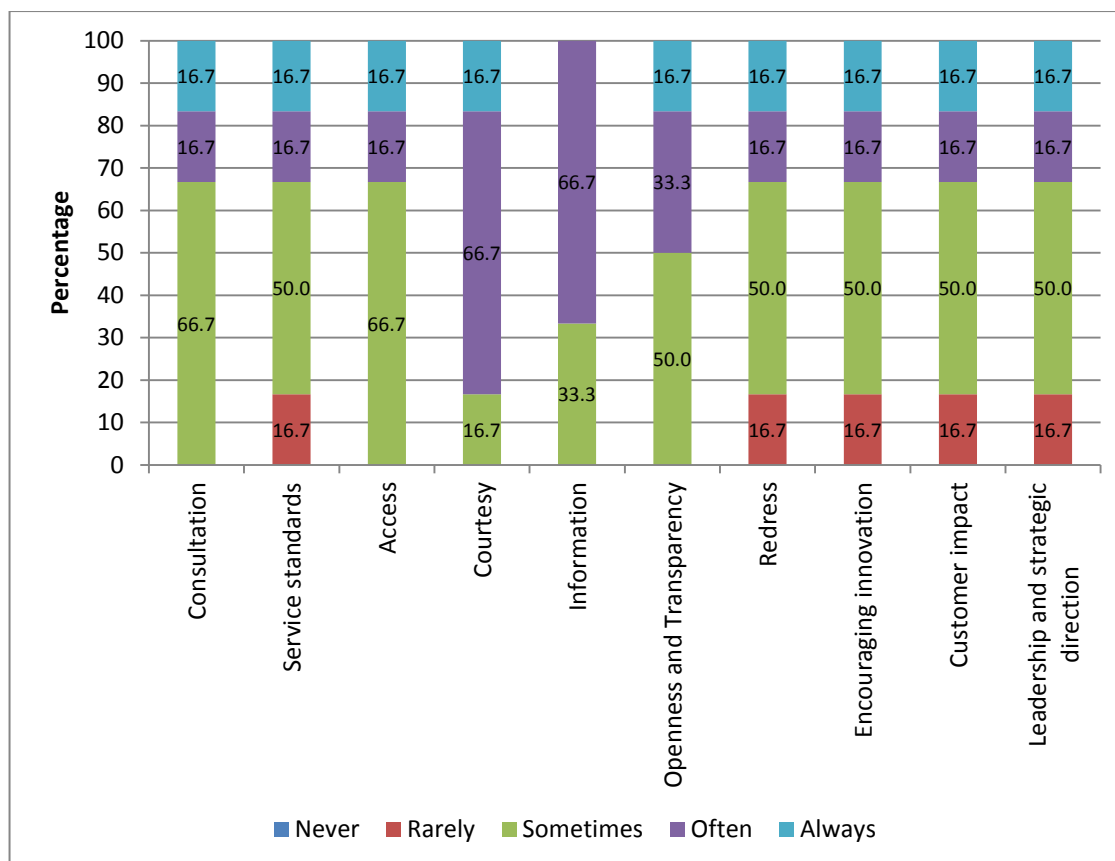


Figure 5.3: Adherence to Batho Pele principles

5.10 SUMMARY OF THE CHAPTER

This chapter presented phase one of the data collection which included the observations of the three PHC clinics and the three CHCs. The following chapter 6 will present phase two of the data collection which was the survey questionnaire completed by the community psychiatric nurses and operational managers.

CHAPTER 6: PRESENTATION OF FINDINGS: PHASE 2 (SURVEY)

6.1 INTRODUCTION

The previous chapter presented phase one which was observations of the six psychiatric facilities. In this chapter the findings of phase two; the survey questionnaires will be presented. The raw data was captured on an excel spreadsheet and was analysed using the SPSS, Version 25. The following tests were used in the analysis of data:

- Descriptive statistics including means and standard deviations, where applicable. Frequencies are represented in tables or graphs.
- Wilcoxon Signed Ranks test: A non-parametric test used to test, in this study, whether the average value is significantly different from a value of 3 (the central score). This is applied to Likert scale questions. It is also used in the comparison of the distributions of two variables.
- Kruskal Wallis Test: Non-parametric equivalent to ANOVA. A test for several independent samples that compares two or more groups of cases in one variable.
- Mann Whitney U Test: Non-parametric equivalent to the independent samples t-test.
- Spearman's correlation: Spearman's correlations measures how ordinal variables or rank orders are related. One sample t-test: Tests whether a mean score is significantly different from a scalar value.

6.2 SAMPLE REALISATION

The facilities that offered psychiatric services within the uMgungundlovu district were identified as the study samples. These included three PHC clinics and three CHCs. The study sample included professional nurses who were in direct contact with MHCUs daily and the operational managers in charge of

the psychiatric facilities. On investigation, it was discovered that in each clinic this usually included two professional nurses who alternated in the psychiatric clinic and the operational manager in charge of the clinic. Based on the numbers received from each clinic, the researcher expected 18 participants to be a part of the study. On arrival at the facilities, the numbers were slightly different. Three participants declined to participate in the study, therefore a total of 15 questionnaires were distributed to all willing participants who met the selection criteria and a 100% (n=15) return rate was achieved.

6.3 PRESENTATION OF RESULTS

The survey questionnaire included two sections. Section A covered the demographics of the participants and Section B captured the participants' contact with the MHCUs and their understanding of PCC.

6.4 SECTION A: DEMOGRAPHICS

Demographical information was elicited so that the researcher could construct a descriptive profile of the participants. This was important because it provided a basis from which to analyse the professional nurses' understanding of PCC. This section describes the demography of the participants in terms of gender, age, ethnic group, place of work, the number of years in nursing practice and job title.

6.4.1 Gender

As indicated in Figure 6.1, the majority who completed the questionnaires were females 93.3% (n=14) with just 6.7% (n=1) being males.

6.4.2 Age

A total of 53.3% (n=8) belonged to the 51-65 age group, 20.0% (n=3) were between 41-50 years, 20.0% (n=3) were between 31-40 years and just 6.7% (n=1) was between 20-30 years old. This is depicted in Figure 6.1.

6.4.3 Race

As illustrated in Figure 6.1, Black South Africans were the majority with 86.7% (n=13), while 13.3% were Indian (n=2). This is presented in Figure 6.1.

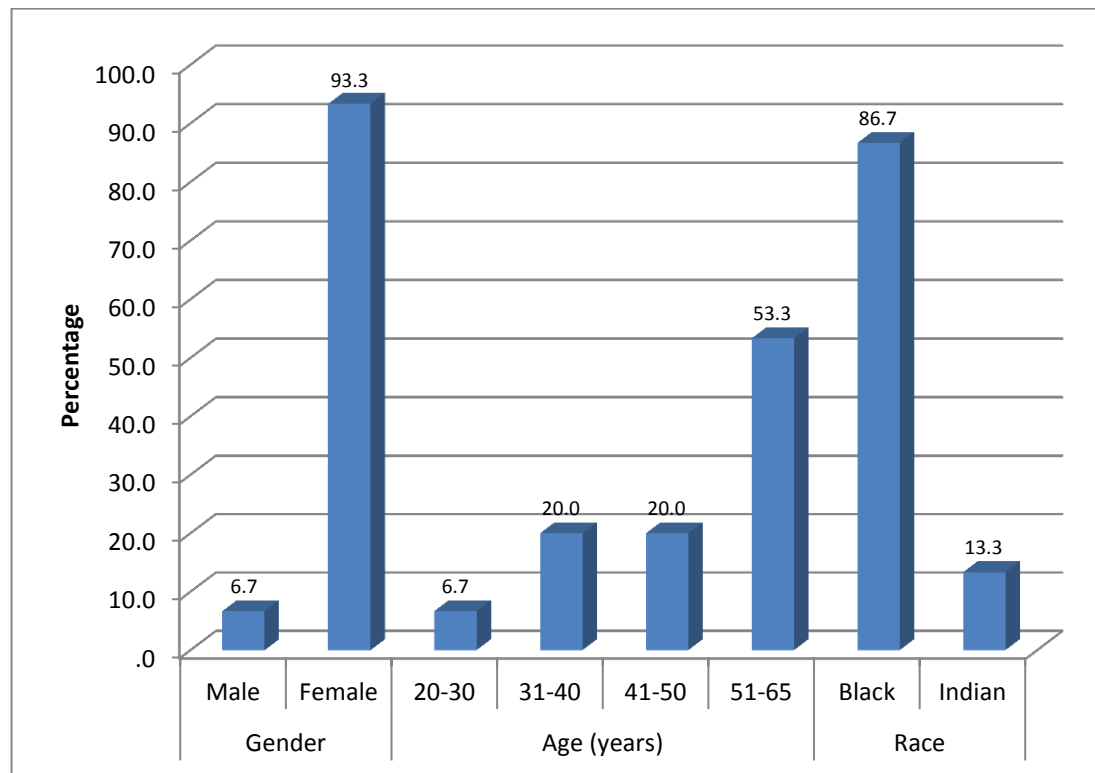


Figure 6.1: Gender, age, race

6.4.4 Place of work

PHC 1 had the most staff of 26.8% (n=4), followed by CHC 3 with 20.0% (n=3). PHC 2 had 13.3% (n=2) and PHC 3 had 33.3% (n=2). CHC 1 had 13.3% (n=2) and CHC 2 had 13.3% (n=2). Table 6.1 shows the distribution of place of work.

Table 6.1: Place of work

Place of Work	Percentage of staff
PHC 1	26.8%
PHC 2	13.3%
PHC 3	13.3%
CHC 1	13.3%
CHC 2	13.3%
CHC 3	20.0%
Total	100%

6.4.5 Experience

Only 6.7% (n=1) had more than 40 years of experience, 40.0% (n=6) had between 10-12 years of experience, 26.6% (n=4) had 20-30 years, 20.0% (n=3) had 30-40 years, with just 6.7% (n=1) having less than 10 years' experience.

6.4.6 Job title

A total of 73.3% (n=11) of the participants were professional nurses and 26.7% (n=4) were operational managers. Figure 6.2 presents the experience and job title.

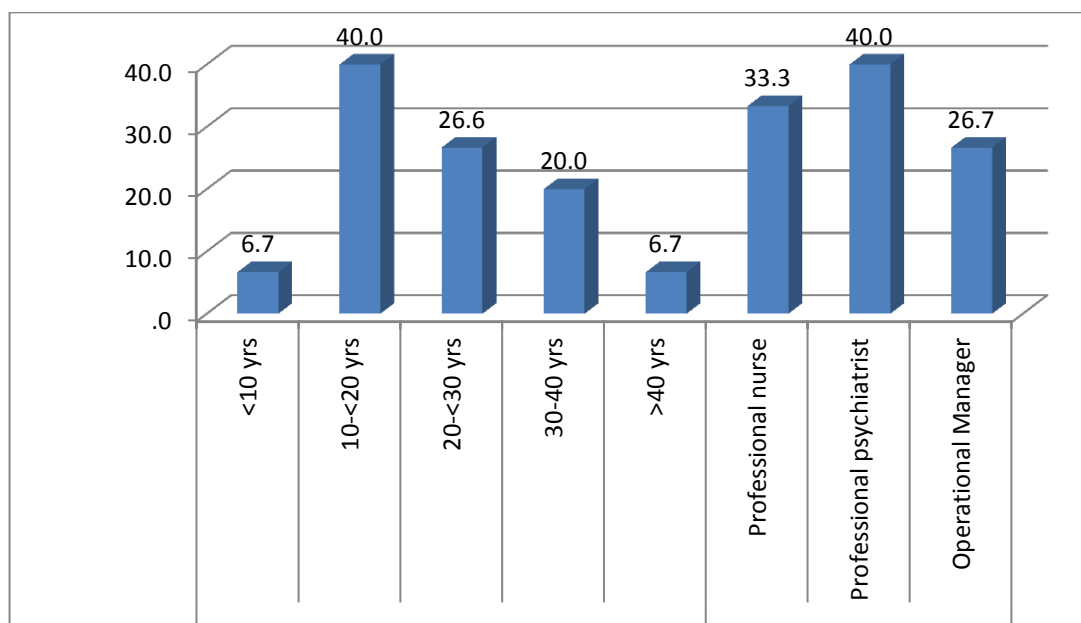


Figure 6.2: Experience and job title

6.5 SECTION B – CONTACT WITH MENTAL HEALTH CARE USERS AND UNDERSTANDING OF PATIENT-CENTRED CARE

In this section, the researcher sought information regarding the professional nurse's contact with the MHCUs and their understanding of PCC. The understanding of PCC encompassed the essential components necessary for the successful delivery of PCC and barriers they encountered with the delivery of PCC.

6.5.1 Contact with mental health care users

The majority than 53.3% (n=8) agreed that they were in contact with MHCUs daily, 40.0% (n=6) strongly agreed and 6.7% (n=1) disagreed. The majority of 46.7% (n=7) agreed that they practiced PCC with every MHCU that they were in contact with, 26.7% (n=4) strongly agreed to this, 13.3% (n=2) disagreed, 6.7% (n=1) strongly disagreed, while 6.7% (n=1) remained neutral. It was reported that 46.7% (n=7) agreed that they were confident in nursing psychiatric patients, 33.3% (n=5) of the nurses strongly agreed. Only 13.3% (n=2) disagreed and 6.7% (n=1) remained neutral. In response to PCC being

beneficial to MHCUs, a total of 46.6% (n=7) agreed, 40.0% (n=6) strongly agreed to this, 6.7% (n=1) disagreed and 6.7% (n=1) was neutral. A fragmented response was received regarding whether mental health care has been effectively integrated into PHC. Almost half of the sample 46.7% (n=7) agreed that mental health care has been integrated into PHC, 13.3% (n=2) strongly agreed, 13.3% (n=2) disagreed, 6.7% (n=1) strongly disagreed and 20.0% (n=3) chose to remain neutral.

A Wilcoxon signed-ranks test was applied to show significant agreement or disagreement regarding the contact that professional nurses had with MHCUs. A significant 14 of the 15 respondents rated their daily contact with MHCUs higher than a neutral score of 3, $Z=-3.226$, $p=.001$. This means that there was a significant agreement that nurses are in contact with MHCUs on a daily basis.

The median Likert score was tested against the neutral score of 3. The disagreements and agreements regarding professional nurse's contact with MHCUs are depicted in Figure 6.3.

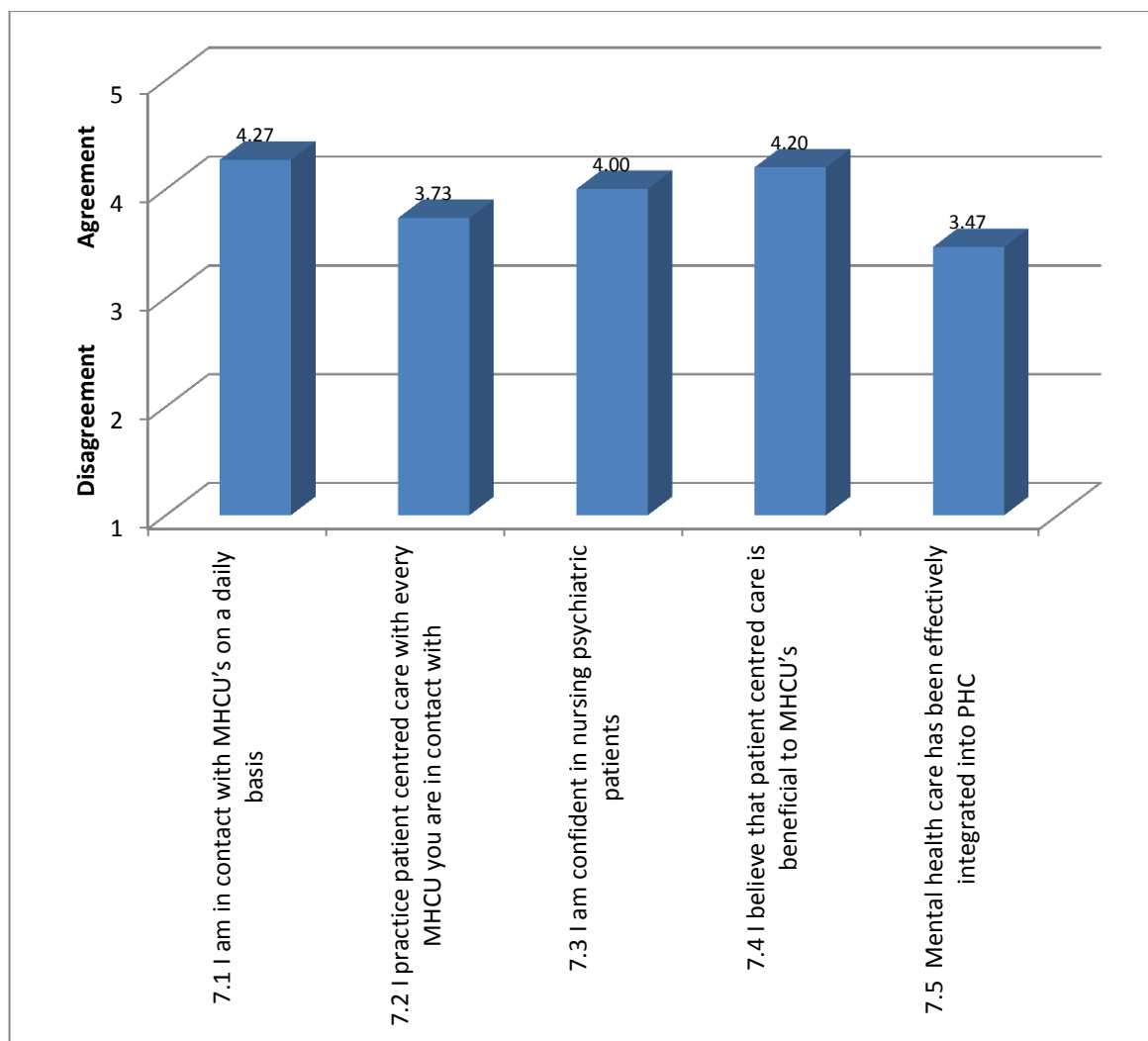


Figure 6.3: Contact with mental health care users

6.5.2 Essential components for the successful delivery of patient-centred care

Ten key essential components were identified to have an impact on the delivery of PCC which included the following areas: open communication, positive work environment, adequate resources, in-service education on PCC, teamwork, support of the MDT, appropriate nurse-patient relationships, adequate staffing, showing respect to MHCUs and taking the patients' culture into consideration. A Wilcoxon signed-ranks test was used to indicate professional nurse's agreement or disagreement to the essential components for the successful delivery of PCC. Professional nurses who neither agreed

nor disagreed, remained neutral. Figure 6.4 illustrates the agreements and disagreements of the essential components for PCC. The results are as follows:

6.5.2.1 Open communication

The majority of participants 86.6% (n=13) agreed that open communication was important, 6.7% (n=1) disagreed and 6.7% (n=1) remained neutral.

6.5.2.2 Positive work environment

In response to a positive work environment being important, the majority of participants 73.3% (n=11) agreed, 20.0% (n=3) disagreed with this statement, and 6.7% (n=1) was neutral.

6.5.2.3 Adequate resources

A total of 86.7% (n=13) of the participants agreed that adequate resources is an essential component in the delivery of PCC, with 13.3% (n=2) who strongly disagreed that adequate resources was an essential component.

6.5.2.4 In-service education on PCC

It was agreed by 73.3% (n=11) participants that in-service education played a role in PCC, although 26.7% (n=4) disagreed with this.

6.5.2.5 Teamwork

Participants agreed 86.6% (n=13) that teamwork is an essential component in PCC. Only 6.7% (n=1) of the participants strongly disagreed and 6.7% (n=1) remained neutral.

6.5.2.6 Support of the Multidisciplinary team

A significant proportion of 86.6% (n=13) agreed that it was important to have the support of the MDT in ensuring that PCC was achieved, 6.7% (n=1) disagreed and 6.7% (n=1) chose to remain neutral.

6.5.2.7 Appropriate nurse-patient relationships

The majority of 86.7% (n=13) of the participants agreed and supported appropriate nurse-patient relationships, with 13.3% (n=2) disagreeing to this.

6.5.2.8 Adequate staffing

About 66.7 % (n=10) reported that adequate staffing was indeed necessary for PCC to be successful, yet a significant number 33.3% (n=5) felt that adequate staff was not required to ensure that PCC was maintained.

6.5.2.9 Showing respect to MHCUs

All participants 100% (n=15) agreed that it was essential to show respect to MHCUs.

6.5.2.10 Taking the patient's culture into consideration

A significant number 86.6% (n=13) agreed that it was important to consider the MHCUs culture in ensuring PCC. Only 6.7% (n=1) disagreed and 6.7% (n=1) was neutral.

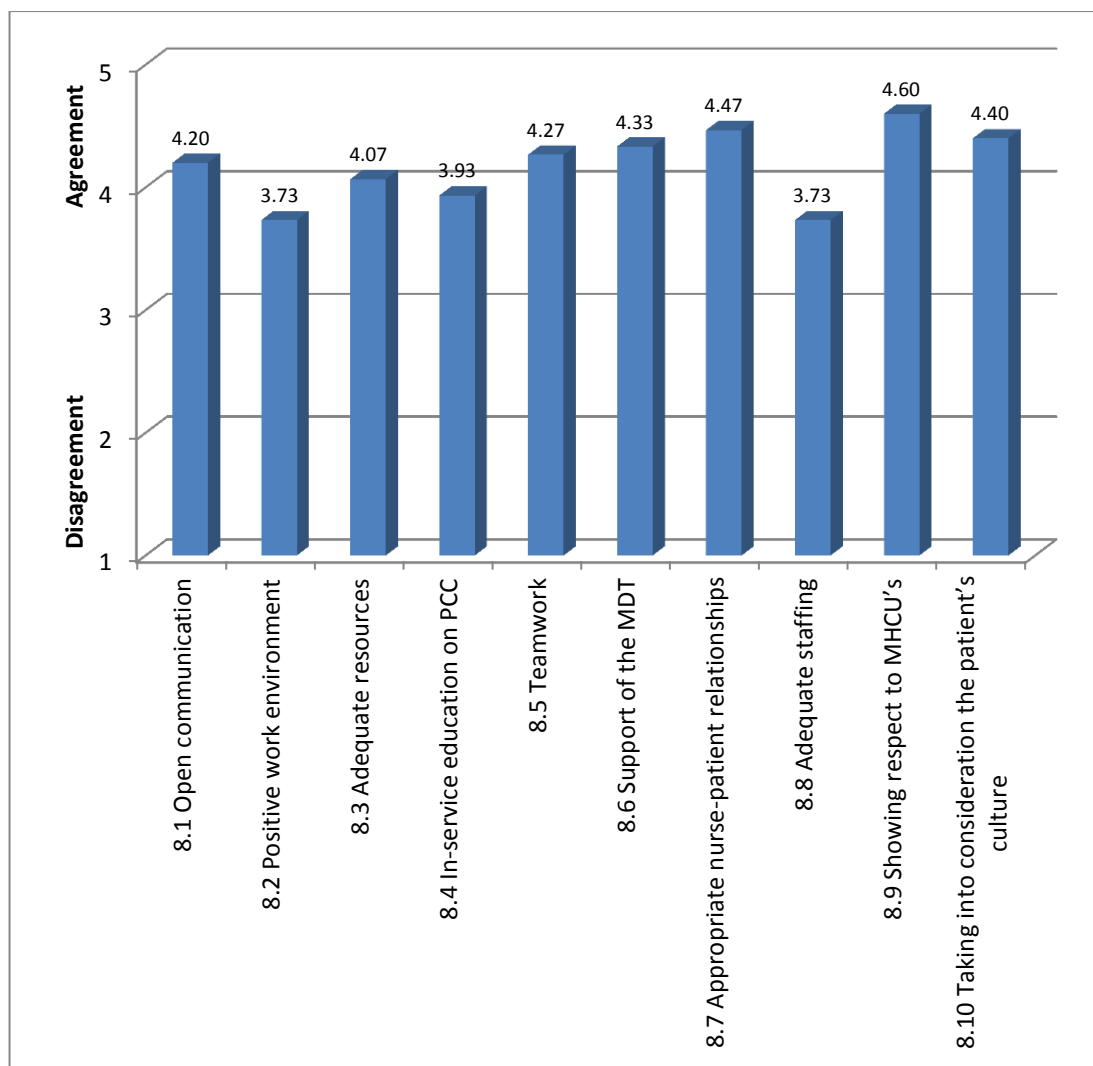


Figure 6.4: Essential components in the successful delivery of PCC

6.5.3 Barriers to the successful delivery of patient-centred care to MHCUs

There were ten factors that were regarded as barriers to the successful delivery of PCC to MHCUs. These included staff shortages, time constraints large numbers of patients, impatient patients, lack of resources, uncaring nurses, inexperienced nurses, inadequate knowledge on PCC lack of support on PCC and language barriers. This is depicted in Figure 6.5. The results are as follows:

6.5.3.1 Staff shortages

All participants, 100% (n=15) agreed that staff shortages were indeed a barrier in the successful delivery of PCC.

6.5.3.2 Time constraints

The majority of the participants, 80.0% (n=12) reported that time constraints directly impacted on their ability to ensure PCC is maintained. Only 13.3% (n=2) disagreed and 6.7% (n=1) remained neutral.

6.5.3.3 Large numbers of patients

A significant number of participants, 86.7% (n=13) agreed that the large numbers of patients attending the psychiatric facilities hindered their ability to always ensure that PCC is practiced. A lesser number, 13.3% (n=2) disagreed with this statement.

6.5.3.4 Impatient patients

All participants, 100% (n=15) agreed that impatient patients were a barrier to the successful implementation of PCC.

6.5.3.5 Lack of resources

The majority of participants, 86.6% (n=13) agreed that there was a lack of resources which impacted on their ability to ensure PCC is enforced, 6.7% (n=1) disagreed and 6.7% (n=1) was neutral.

6.5.3.6 Uncaring nurses

More than half of the participants, 53.4% (n=8) disagreed that uncaring nurses were a barrier to PCC, whilst 33.3% (n=5) were in agreement. The minority of 13.3% (n=2) chose to remain neutral.

6.5.3.7 Inexperienced nurses

More than half of the participants, 73.4% (n=11) agreed that inexperienced nurses were a barrier to ensuring that PCC was achieved, yet 26.6% (n=4) disagreed with this statement.

6.5.3.8 Inadequate knowledge on patient-centred care

Participants agreed 60.0% (n=9) that inadequate knowledge on PCC is a barrier, while 33.3% (n=5) disagreed and 6.7% (n=1) remained neutral.

6.5.3.9 Lack of support from management

More than half of the sample, 60.0% (n=9) agreed that a lack of support from management was a barrier to successful PCC, 26.7% (n=4) disagreed and 13.3% (n=2) were neutral.

6.5.3.10 Language barriers

Participants agreed 53.3% (n=8) that language was a barrier to PCC, 40.0% (n=6) disagreed and 6.7% (n=1) remained neutral.

Figure 6.5 presents the mean averages of the barriers in the successful delivery of PCC.

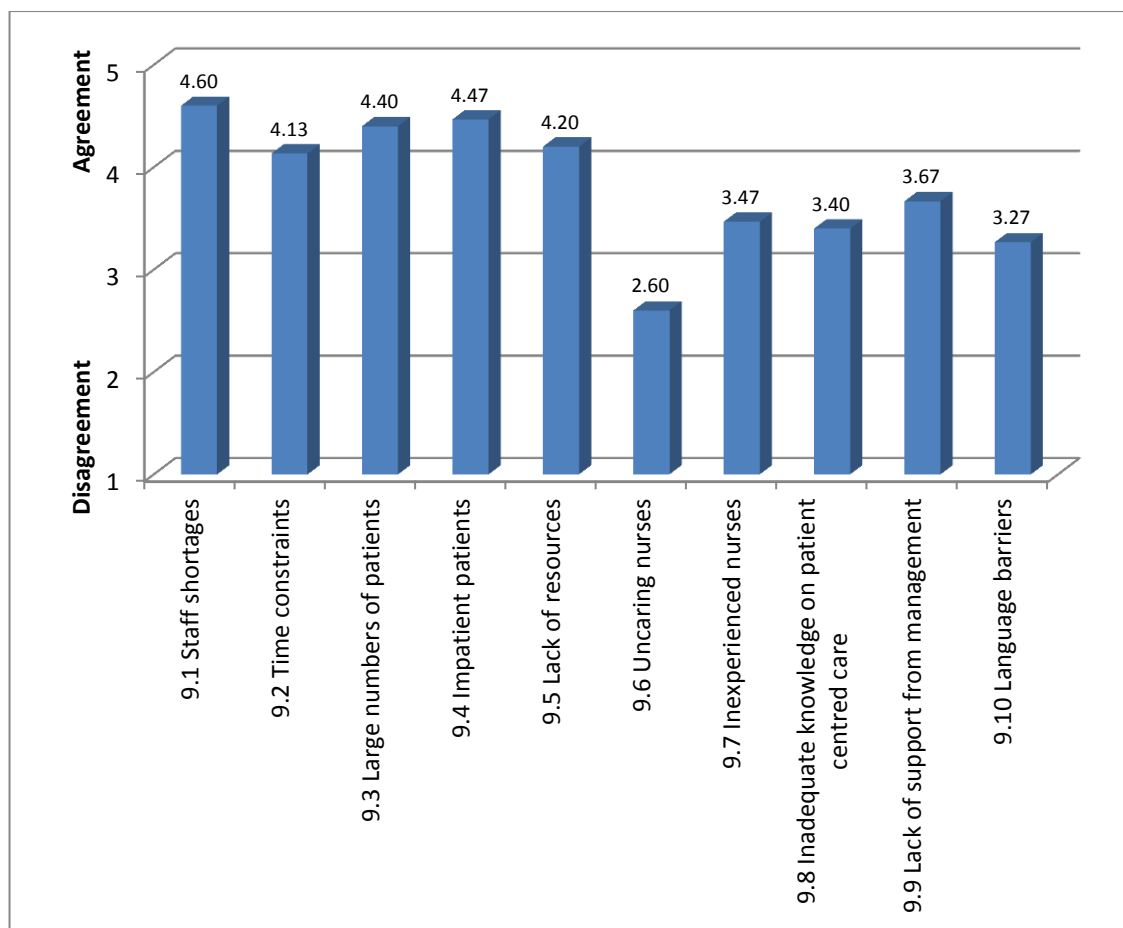


Figure 6.5: Barriers in the successful delivery of patient-centred care

6.6 SUMMARY OF THE CHAPTER

In this chapter the results of phase two: survey questionnaire was presented. Chapter 7 presents the results of phase three of the data collection being one-on-one interviews.

CHAPTER 7: PRESENTATION OF FINDINGS: PHASE 3 (ONE-ON-ONE INTERVIEWS)

7.1 INTRODUCTION

The previous chapter propagated the results of the survey questionnaire. The findings of the final phase of the data collection being one-on-one interviews will be presented next. The interview guide used in Phase three consisted of Section A which covered the demographic data of the participants and Section B included the research questions that were posed to the participants.

7.2 DEMOGRAPHIC DATA FOR THE INTERVIEW PARTICIPANTS

This section presents the personal information of the participants including race, age, gender, marital status, religious practices and years of experience working at a psychiatric clinic. The age, gender and race are depicted in figure 7.1. The majority, 93.3% (n=14) of the participants were female and 6.7% (n=1) were male. A total of 53.3% (n=8) were between 51-65 years of age, 20.0% (n=3) belonged to the 41-50 year age group, 20.0% (n=3) were between 31-40 years of age and 6.7% (n=1) was in the 20-30 age group. Most of the participants, 86.7% (n=13) were Black South Africans while 13.3% (n=2) were represented by the Indian population group.

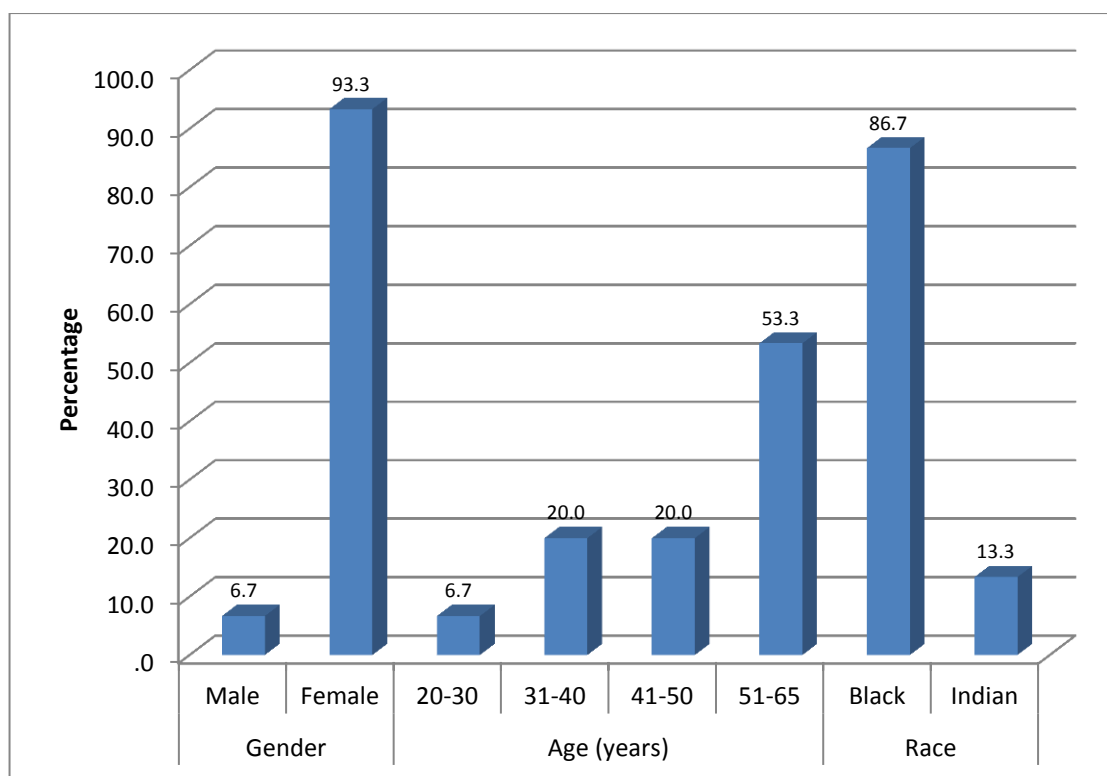


Figure 7.1: Gender, age and race

Table 7.1 presents the marital status, religious practice and years of experience working at a psychiatric clinic. A total of 46.7% (n=7) of the participants were married, 33.3% (n=5) were single, 13.3% (n=2) were either divorced or separated, 6.7% (n=1) was widowed and there were no participants that were cohabiting. The majority of 80.0% (n=12) belonged to the Christian faith, 13.3% (n=2) were Hindu and 6.7% (n=1) was of the Nazareth faith. There were no participants who belonged to the siSwati, Muslim or any other religion. Analysis showed that 33.3% (n=5) of participants had less than 5 years of experience working at a psychiatric clinic, 33.3% (n=5) had between 5 to less than 10 years, 13.3% (n=2) reported having 15 to less than 20 years, as well as 13.3% (n=2) with more than 20 years' experience. Only 6.8% (n=1) had between 10 to less than 15 years of experience.

Table 7.1: Marital status, religious practice and years of experience in a psychiatric clinic

		Frequency	Percentage
Marital status	Single	n=5	33.3%
	Married	n=7	46.7%
	Divorced/separated	n=2	13.3%
	Widowed	n=1	6.7%
	Cohabiting	n=0	0%
Total		n=15	100%
Religious practice	Christian	n=12	80.0%
	siSwati	n=0	0%
	Muslim	n=0	0%
	Nazareth	n=1	6.7%
	Hindu	n=2	13.3%
	Other	n=0	0%
Total		n=15	100%
Years of experience at a psychiatric clinic	Less than 5 Years	n=5	33.3%
	5 - <10 Years	n=5	33.3%
	10 - <15 Years	n=1	6.8%
	15 - <20 Years	n=2	13.3%
	More than 20 Years	n=2	13.3%
Total		n=15	100%

7.3 PRESENTATION OF FINDINGS

One- on- one interviews were conducted with all consenting participants across the six community psychiatric facilities. The operational managers in charge of the clinic and professional nurses who were in direct contact with MHCUs daily were approached to be a part of this study. A total of 15 out of a possible 18 participants agreed to be interviewed. The analysis of data was guided by Creswell (2009: 185-190) who suggested that the content of data is analysed and coded until themes are realised. As suggested by Creswell (2009: 185-190), the researcher adopted the following steps that guided the analysis of data:

- The interviews were transcribed and typed out verbatim.
- All transcripts were studied and analysed to obtain an understanding of the interviews and identify the embedded meanings.

- All data was organised into sections and phrases or words were labelled and categorised.
- Major themes were identified and further analysed until sub-themes emerged.

Three broad questions were asked during the interview process. To gain a complete understanding of participants' responses additional probing questions were asked. The research questions were as follows:

- What strategies are used to implement PCC for MHCUs?
- To what extent has mental health been integrated into PHC?
- What changes would you propose to enhance PCC for MHCUs?

The researcher was able to identify the following themes and sub-themes which are summarised in table 7.2.

Table 7.2: Major themes and sub-themes

Major theme	Sub-theme
1. Strategies used to implement PCC for mental health care users.	1.1 . Holistic care. 1.2 . Fast tracking of MHCUs. 1.3 . Screening of MHCUs.
2. The extent to which mental health has been integrated into primary health care.	2.1 . Prescripts of the ideal clinic. 2.2 Mental health care users' temperament. 2.3 Promoting nurse –patient relationships.
3. Changes proposed in order to enhance PCC for mental health care users.	3.1 . Lack of training. 3.2 . Poor Infrastructure. 3.3 . Shortage of staff. 3.4 . Lack of home visits.

7.4 MAJOR THEME 1: STRATEGIES USED TO IMPLEMENT PATIENT-CENTRED CARE FOR MENTAL HEALTH CARE USERS

The sub-themes identified to be related to strategies used to implement PCC for MHCUs were holistic care, fast tracking of MHCUs and screening of MHCUs. These sub-themes are explained further in detail below.

7.4.1 Holistic care

It was a consensus that professional nurses who worked daily with MHCUs try their best to provide holistic care to their patients. They verbalised trying to incorporate the changes that had to be implemented with the integration of services. Although in doing so, ensuring that MHCUs were attended to holistically was seen to be a challenge. The following are excerpts from the interviews support this theme:

“Ya, we had to make changes, but we tried to implement the changes, but seemingly they did not work, we are trying our best to focus on them”. (PHC #3; OM)

“They are seen holistically, when they come for their medications, if they have the flu or whatever, they can collect everything on one room. If they have high blood pressure, are diabetic or on ARVs, yes they get everything here in one place”. (PHC #1; PN #1)

“We don’t refer them for other services that can be rendered by a Professional nurse, diabetes, hypertension, and flu, all that is seen to when they come to collect their psychiatric medication”. (PHC #1; PN #3)

“We have the chronic stream, but within that chronic stream, we have the mental health area, or a room dedicated to mental health patients. A professional nurse deals specifically with mental health patients where they collect all their chronic medications, they will be seen in that room for everything”. (PHC #3; PN #2)

“I don’t think I am able to give holistic care; I don’t know what to say, I work here by myself, I screen, I see the patients, I give medications, I do everything by myself”. (CHC #2; PN #1)

7.4.2 Fast tracking of MHCUs

Professional nurses believed that fast tracking of MHCUs promoted PCC, as MHCUs were given priority above other general chronic patients. They reported that this was a strategy that they had to use for the clinics to run smoothly, taking into consideration the attitude and behaviour of mentally ill patients. This however was not in line with the integration of services. The following excerpts support this:

“.....we try to accommodate them a little more separately in the chronic stream, the queues are too long and the mental health patients are impatient. We almost have to create a separate stream within the chronic stream. We have the mental health area, or a room dedicated to mental health patients with an RN dealing specifically with mental health patients. They collect all their chronic medication; they will be seen in that room for everything”. (PHC #1; OM)

“Okay, we transfer them, we don’t make them wait in the queue like other patients. So, we just fast track them. Usually they don’t come to the front desk unless they are going to see the doctor, they go straight to collect their medication. They don’t follow the normal row like everyone else. there is prioritising depending on their condition and whatever, so they are being fast tracked, to fast track them because they cannot wait like other people”. (PHC #2; OM)

“The needs of the chronic psychiatric patient is not the same as the general chronic patient, they can’t wait a long time in the queue like other patients”. (CHC #2; PN #1)

“We are still separating them from the general chronic stream, even though they come here, they may have other problems like hypertension”. (PHC #1; PN #4)

7.4.3 Screening of MHCUs

The participants reported that screening of psychiatric patients was recently introduced. Participants expressed that initially, patients did not agree with this strategy, although professional nurses reported that it did contribute towards ensuring that the care provided was patient-centred and holistic. In this way, other medical problems could be identified, and appropriate interventions implemented. The following excerpts provide evidence of this:

“Screening is done for all patients, even psychiatric patients because we have to assess and find out the health of that patient. We have the tool in the screening area that we have to ask those questions, just like tuberculosis and diabetes and all that. It is more or less like a questionnaire, asking them about how they are sleeping and if they are experiencing any cough and so on”. (PHC #2; PN #2)

“We just focus on them; we screen them and then they have to go to the specific sister to see them. I feel this helps us to ensure that all the needs of our patients are seen to”. (PHC #3; OM)

“As soon as the patients come in, they get their files and they have to be screened. In this way all the needs of the patient are met, and each patient gets the care they need”. (CHC #2; PN #1)

“Their files have all been put in one place and then the client comes and collects their files and then they check their blood pressure or blood sugar and all the observations that need to be done. They are being screened by the sister, then they are sent to pharmacy to collect their medication”. (CHC #3; OM)

7.5 THE EXTENT TO WHICH MENTAL HEALTH HAS BEEN INTEGRATED INTO PRIMARY HEALTH CARE

There were several mixed views regarding the extent to which mental health has effectively been integrated into PHC. However, most of the participants related the integration of services to the prescripts of the ideal clinic. The participants highlighted the fact that complete integration was difficult due to various contributing factors. The sub-themes that emerged were prescripts of the ideal clinic, MHCUs temperament and promoting nurse-patient relationships. The sub-themes are further explained below:

7.5.1 Prescripts of the ideal clinic

The participants explained that according to the prescripts of the ideal clinic, the patients were now separated into three streams, namely acute, chronic, mother and child. There was no special provision made for psychiatry. MHCUs were now categorised under the chronic stream and had to follow the same queue and prescripts of chronic patients. Participants expressed that they tried their best to ensure that they follow the guidelines proposed by the ideal clinic, although this was not always possible when it came to MHCUs and psychiatry. The majority of the participants agreed that most services were effectively integrated, although this was not the case for mental health. The following excerpts support this:

“Err...you know with us, as you know the ideal clinic is suggesting that there should be three streams, it's chronic, mother and child and acute. So, since we get into the chronic, I am talking about TB, HIV, hypertension, diabetes and epilepsy. It hasn't been like that, we used to be our own, now we are being incorporated to the chronic side.....so yes, I would say according to the ideal clinic we are providing patient-centred care. Although I would say psychiatry is specialised, it should be on its own, although somebody may argue that it is discrimination. The needs of the psychiatric patient cannot be the same as the chronic patient. They cannot wait for a long time and there are a lot of chronic patients”. (CHC #2; PN #1)

"I think it is 'yes' and 'no'...it is integrated into PHC however because of the large numbers of patients that we see in this clinic, it needs to be separated, as I am saying we have a separate room. According to the ideal clinic, National has implemented the screening of all patients in a central place for all clients visiting the clinic. The MHCUs are our biggest barrier with that, they are used to going to a separate clinic on their own which was quite fast. They don't see the need for having their blood pressure taken if they have come just to collect their medication". (PHC #1; OM)

"Ahh...the records were not integrated in terms of the record-keeping, because if you look at the new health patients' registration system file, there is very little information on MHCUs. I don't think they took that into consideration when they were integrating mental health with PHC. They should have integrated the records as well and catered for MHCUs as well, because now we still have to use the old brown folders as there is not enough space to document everything in the new file". (PHC #3; OM)

"It has gone wrong; I don't really know what the purpose of this ideal clinic was and how it came about. Yes, they said they had all the glitterati said about it, but when you look deep down, some of the things are not done. It's like icing a cake that is raw. On the outside it looks good but come inside you will find that pieces are just thrown. The record book that has been recommended is not adequate in order to capture information regarding mental health". (PHC #2; PN #2)

"Err...integration is not a problem, if it was implemented as it was in the document, there was a document we were shown about integration. It looked patient-centred, but it was not implemented. The holistic care of the psychiatric patient in the community was compromised and is further being compromised". (PHC #1; PN #3)

7.5.2 Mental health care users' temperament

The participants expressed that as much as they wanted to follow the directive from the Department of National Health and integrate services as suggested, this was near impossible when it came to psychiatric patients. They agreed that in theory, it would eliminate the stigma attached to MHCUs if they were in the same queue as the other chronic patients, although MHCUs do not possess the same temperament as mentally healthy persons. Their sentiments below support this:

"Because of the patient's temperament and the way that they behave, we have to create a different stream for mental health, so that they are treated by specific nurses. MHCUs do not like change, they want the routine, when we try to implement changes, and they are very reluctant. MHCUs are very impatient and they refuse to stand in queues, some are very temperamental and begin to cry and fight. MHCUs refuse to join the mainstream". (PHC #1; OM)

"You know psychiatric patients, some of them are very impatient, when you work here you know your patients and you know that certain patients won't wait for a long time, you have to go and make sure that you fast track him and make sure that you see him, if not if he is not seen within 30 minutes and he is not accompanied by somebody, he will just leave. Then we are worried that he will not have any medication and he will relapse. One patient told me that they cannot sit in a place where there are many people. One day he was just standing in the veranda smoking and his transport came for him, he just left without getting his medication". (PHC #1; PN #3)

"People don't realise that psychiatric patients are so unstable, one minute they are stable, the next minute they are psychotic". (CHC #2; PN #1)

"The patients want stability; they are like babies..." (PHC #3; PN #2)

“Well, if I am honest, I don’t think that it has been effectively integrated into PHC. We are still separating them and trying to fast track them so they don’t get agitated”. (CHC #3; PN #3)

“There should be a clinic every day, here it is only on a Tuesday, ya it is not every day, they are impatient. They need care, if you put them aside and sometimes you find that when they come in, they are very irritable”. (PHC #3; PN #3)

7.5.3 Promoting therapeutic nurse-patient relationships

Throughout the interviews, the psychiatric nurses stressed that it was important to gain rapport and secure a trust relationship with MHCUs. To provide PCC, a strong nurse-patient relationship was vital. They reported that the changes that had taken place with the integration of services gave rise to professional nurses rotating between the PHC clinics and psychiatric clinics. This appeared to present challenges. The following extracts support this sub-theme:

“What we have noted is that psychiatric patients want that stability, if they see a new face that we are changing now and again, they are not happy. We have to build that relationship with them so that they trust you. If you are changing every time, they are not used to the face they are seeing. Here we are changing every three months”. (PHC #1; PN #2)

“Trust and rapport with these patients are very important. Because if you know you have done mental health, you know these patients, it goes beyond just swallowing tablets”. (PHC #1; PN #3)

“We don’t get to know our patients well, because there is always a change in the shift. We used to remain in this clinic for six months or more, it worked well. If this clinic was run every day for the whole day, we may be able to spend more time with our patients”. (CHC #1; PN #1)

"I sit down, I ask the questions and then give his medications. Patients here are quite proactive, whereby they want to know about everything you are doing. You have those patients who are introverts, so you have to dig a bit to get information, although where is the time to dig and ask questions". (PHC #3; PN #2)

"...so many long for a listening ear and we don't do that, we just summarise what they say and let them go, we can see that they want to talk, but we don't have the time. We think we will catch up on the next visit, but by then we may have rotated". (CHC #1; PN #2)

7.6 CHANGES PROPOSED TO ENHANCE PATIENT-CENTRED CARE FOR MENTAL HEALTH CARE USERS

The majority of the participants agreed that given the circumstances, they attempted to prioritise and provide care that is holistic and patient centred. However, they did propose some recommendations for change to mitigate the challenges that sometimes hinder their ability to provide holistic patient-centred care. They reported that these changes could enhance their ability to provide PCC effectively and efficiently. The sub-themes that surfaced were lack of training, poor infrastructure, shortage of staff and lack of home visits.

7.6.1 Lack of training

Participants expressed that with all the changes that have been proposed regarding the ideal clinic and the integration of services, it was not accompanied by any form of training or updates. Most of the time, they were informed via their management that changes were needed and they have to implement the changes. They further explained that many aspects were changing with regards to the care of patients, yet updates or in-service training to improve their knowledge regarding how the integration would enhance PCC did not take place. The following are excerpts to support this sub-theme:

“For now I did my mental health training when I did my four- year course and we haven’t been doing it, now you are pushed into it and you are expected to run it and it is difficult as there has been no training or workshops. If management can assist us with proper in-service, as we don’t want things just as face value, we want to give holistic care. We need to know which questions to ask and which tools to use as well. I think we are lacking that. For health care workers to be educated so that we are able to assist our clients”. (PHC #2; PN #1)

“We have to rotate every 3-4 months and things are not the same in every clinic. Presently here, there is not many of us who have psychiatric training. There is only a handful of us with psychiatry”. (CHC #1; PN #1)

“I am PHC trained, but I feel I cannot cope. Everyone is busy, there is no else to help, we do the best that we can”. (CHC #2; PN #1)

“Aye, ya we need in-service regarding things that are keeping on changing”. (PHC #1; PN #4)

“There was no orientation when I came here, I was doing antenatal, and how am I going to do psychiatry? I need some orientation. Yes, I am psychiatric trained, but I have never been in practice. I was a fish out of the water until it came to me. Yes, we went to the head office, it was something new. They were just throwing information at us; we didn’t even understand what was going on”. (PHC #3; PN #2)

7.6.2 Poor infrastructure

Most of the participants shared the similar sentiments about the infrastructure and how it impacted on their inability to work effectively. Their main concerns revolved around space. The lack of space led to a lack of privacy with their clients as other health care workers sometimes also shared the same room or stored their equipment in the same room. This resulted in other members of

the MDT walking in while a patient was being interviewed or examined. The same room was used for administration of injections, which was not conducive to ensuring patients' privacy. Participants reiterated that this did not promote PCC. The following statements support this sub-theme:

"I feel like even the infrastructure needs to change or something like that. We don't have the facilities, there are rooms, but if you look in terms of space, it is very small. Especially when you look at the sister who is seeing these patients, the room is very small, she's got to do everything in there, interview them, give them injections and medication in that one small room. There is no space for screens or anything separating". (PHC #3; OM)

"When the client comes in, you attend to them holistically and you ask all spheres, socially, mentally. We try to have open communication, but you find that people are coming in and out all the time, there is no privacy. If I had the space, I would have a desk in here for the medication and treatment cards and their files or records. Everything with the chart and medications placed together, so when they come, I know it will be easier". (PHC #3; PN #2)

"Hey, it is the structure, that's the main problem because that side there are so many procedures happening there, emergencies are attended to so at times there is not enough space". (CHC #3; PN #2)

"We don't have the space to accommodate our patients, we all use this one room and give medications and injections here as well". (CHC #3; PN #3)

"Office space is a problem, as I am saying, if I had space, I was going to organise the treatment as it comes and prepare them alphabetically and makes sure everything runs smoothly". (PHC #1; PN #2)

"There's no privacy, sometimes patients have other medical problems, and then I have to go to the PHC section as this place doesn't even have a sink". (CHC #1; PN #2)

7.6.3 Shortage of staff

Participants reported that staffing shortages are an ongoing problem. Posts have been frozen and therefore they have learned to work with minimal staff. They also expressed that not all the staff were trained in psychiatric nursing, which then placed added pressure on those that were psychiatrically trained. In some of the facilities, professional nurses were required to rotate every 3-6 months or 6-12 months. Professional nurses without the relevant qualifications did not rotate to the psychiatric clinics. The following excerpts support this theme:

“The problem that we have here is staff shortage. The patients are very impatient, but we cannot help that they have to wait a long time as there are only a few of us and many patients to see. In order to rotate between the clinics as they are suggesting, we need to have enough staff, but we don’t, and it is always a problem”. (PHC #1; PN #4)

“Our problem here is that the psychiatric clinic is only open till 12 noon, because we are short staffed. We have to finish the clinic here by 12 o’ clock and go onto the PHC side and carry on seeing patients there. Our patient load is a lot, in the whole clinic we are seeing more than 600 patients a day. We try and push out as much work and patients before 12, as much as we can”. (CHC #1; PN #1)

“I don’t know what to say, I work here by myself, there is no staff. I screen the patients, give medication and give injections”. (CHC #2; PN #1)

“Staffing is a huge challenge for us, I think that if we had more staff it would definitely help”. (CHC #3; PN #3)

7.6.4 Lack of home visits

Participants reported that home visits were no longer done due to the integration of mental health into PHC. This was raised as a concern as it is a vital part of the monitoring and evaluation of MHCUs in the community psychiatric setting. Professional nurses expressed that they feel they have lost touch with the psychiatric patients and have no way of monitoring or following up with them especially when they default and fail to attend the clinic. Most of the clinics now use tracers, who are a part of a non-governmental organisation, that trace patients with tuberculosis and ensure that they comply with their treatment. These individuals are not nurses or have no psychiatric training or experience. Participants emphasised that home visits extended far beyond just tracing the patient but allowed them to monitor the patient holistically as well as assess their standards of living. Participants stressed that this was a vital component in psychiatric nursing to ensure PCC. The following are excerpts that support this sub-theme:

“No home visits are done anymore, as now we have to work between the psychiatric clinic and the other primary health clinics. Before we used to concentrate on the psychiatric patients, and we planned our visits. We do have tracers, but they are not used for psychiatric patients. The problem is that we never get to tackle our defaulters. I also believe that we as nurses should be able to still follow up with our patients and do home visits, especially for those who are defaulting”. (CHC #1; PN #1)

“Before this thing was given to the community care givers (CCGs), we used to do home visits, but now it is no more. We used to have a car, those patients that are not coming to the clinic, we used to go to their homes and look for them. It used to help other problems, like sometimes we find a child that is neglected or retarded. We used to then refer to the social worker, now it doesn't happen, now we are full time in the clinic. Home visits will make a difference, yes because sometimes they used to refuse to come, so we used to go and give their injections at home. If a family member reports that they

are having a problem, we used to finish our work and then go and assess the patient and give treatment, but that has fallen off". (PHC #1; PN #2)

"I feel that with the integration, mental health is compromised. If I say compromised, I mean previously there were home visits, transport that was dedicated for home visits, it was a psychiatric nurse who did home visits. There is no nurse. When we ask about home visits, we are told about tracers who are not psychiatric trained. If I have a psychiatric patient that needs to be traced, I must give to the tracers..... the tracer who is not trained in psychiatry. The tracers will not be able to assess the patient and the environment as the psychiatric nurse would be able to. They are not nurses; they trace TB patients". (PHC #1; PN #3)

7.7 SUMMARY OF THE CHAPTER

This chapter provided a summary of phase three of the data collection which was the one -on -one interviews. The main themes and sub-themes from these interviews were presented. The next chapter will present a discussion of the findings.

CHAPTER 8: DISCUSSION OF THE FINDINGS

8.1 INTRODUCTION

The previous three chapters presented the findings of the three phases of data collection. In this chapter, the findings are discussed in line with the study objectives. Relevant literature is used in the discussion of the results that either support or refute the findings. The discussion also integrates the theoretical framework that guided the study.

8.2 NURSES UNDERSTANDING OF PATIENT-CENTRED CARE AT COMMUNITY PSYCHIATRIC CLINICS

To gain insight into the professional nurse's understanding of PCC, ten components for the successful delivery of PCC was used. The results of the current study revealed that professional nurses that were in direct contact with MHCUs strived to give off their best to their patients which according to them, this was the crux of PCC. Most of the professional nurses agreed that they practiced PCC with every patient that they were in contact with. This finding was similar to that of a study by Ghane and Esmaeili (2019: 385), who reported that nursing students believed that whenever a patient is cared for, it is inevitably patient-centred, otherwise it would be meaningless. They further stated that the patient should always be the centre of all patient-related activities. Nurses must ensure that they address all the patient's needs and problems.

In the current study, all participants reported that to provide effective PCC, it was essential to show respect to MHCUs. In doing so, it was important to consider the MHCUs culture as this would ultimately affect the care of the patient and how the MHCUs perceived the care provided. According to Neuman's Systems Model (Memmott *et al.* 2017: 58-73), patients are subjected to extra personal stress which relate to the forces that occur as a

result of the wider environment or culture in which the patient lives. This was a significant aspect for professional nurses to consider when providing PCC to MHCUs. Some of the other key components that the participants felt were vital for the delivery of PCC were open communication, teamwork, appropriate nurse-patient relationships, adequate and updated in-service on PCC. The results in this study were consistent with other studies that viewed similar key components to be essential in PCC (Fix, VanDeusen, Lukas, Bolton, Hill, Mueller, LaVela and Bokhour 2018; Ghane and Esmaeili 2019; Wong, Mavondo and Fisher 2020).

Neuman's System Model (Memcott *et al.* 2017: 58-73) encourages health care workers to focus on patients holistically, promoting health and maintaining wellness. The Neuman's System Model suggests that when a nurse cares for a patient, the whole person is taken into consideration. Interventions that are implemented are in light of patients' responses to different variables that affect their health and wellbeing. In the current study, the results support this model as professional nurses reported to always place the patient at the centre of care, ensuring that the patient comes first.

Ghane and Esmaeili (2019: 386-389) studied student nurses' perceptions of PCC. The results revealed that proper communication and education regarding the patient and their needs, together with teamwork, would assist the nurse in implementing PCC effectively. Taking into account the nursing process, student nurses believed that PCC was a part of the comprehensive patient care that nurses are supposed to provide. They further stated that an appropriate nurse-patient relationship is important and sufficient time should be provided to allow patients to ventilate and air their views (Ghane and Esmaeili 2019: 387).

In the current study, participants reported that teamwork as well as regular updates and in-service on PCC would be beneficial to their performance in the clinical setting. Literature supports the current findings as effective teamwork has been proven advantageous in a variety of settings especially in

healthcare, allowing the multidisciplinary teams to work together towards common goals (Cutler, Morecroft, Carey and Kennedy 2018; Oppert, O'Keefe and Duong 2018; Ritterman, Rose, Meyer, Hall, Mirlande, Rankin and Baltzell 2017). Ritterman *et al.* (2017: 118) further stated that creating learning opportunities in the clinical setting increased the prospects for continuing education promoting PCC and interprofessional teamwork.

Professional nurses in the current study reported that open communication was an important component in the delivery of PCC. Griffiths (2017: 593-597) argued that if nurses took the time to listen more intently to their patients, they would be able to obtain a more holistic picture of the patients' problems and appropriate advice could be provided. Taking the time to listen prevented impulsive advice and assisted the patients to participate in finding resolutions to their difficulties. This was reiterated by Fix *et al.* (2018: 302) who contended that PCC was often viewed as a partnership between patients and healthcare workers, allowing patients to play an active role in their care, and in this way the patient was the centre of care and attention.

8.3 BARRIERS THAT PREVENT THE SUCCESSFUL IMPLEMENTATION OF PATIENT-CENTRED CARE WHEN CARING FOR MENTAL HEALTH CARE USERS

Barriers that prevented the successful delivery of PCC was elicited during phase two of data collection. The findings of the current study revealed that there was consensus regarding the barriers that stood out and were viewed as a definite hindrance. More than three-quarters of the participants viewed the following factors as barriers; staff shortages, time constraints, large numbers of patients, impatient patients and inexperienced nurses. The findings of the barriers in the current study were similar to barriers of PCC in other studies done globally (Thomson, Outram, Gilligan and Levett-Jones 2015; Mburu and George 2017; Moore, Britten, Lydahl, Naldemirci, Elam and Wolf 2017; Oppert *et al.* 2018).

Mburu and George (2017: 1-8) conducted a study to determine the challenges that health personnel working in rural areas are faced with. Amongst other challenges, those that were consistent with the findings of the current study was a lack of human resources, high numbers of patients and the lack of professional development. Health care professionals reported working under stressful conditions as their patients came from afar and added pressure was placed on them to give their full attention. They further argue that their lack of opportunities to improve on their skills and knowledge impacted on the quality of patient care delivered. Moore *et al.* (2017: 662-673) explored the barriers and facilitators in the delivery of PCC in healthcare settings. Adequate and ongoing training was necessary to ensure that healthcare workers were prepared and knowledgeable to provide effective PCC. The common barriers consistent with the current study were time constraints and a lack of professional training and education.

In the current study, all professional nurses were in agreement that impatient patients posed a barrier to the successful implementation of PCC. These results are supported by the Neuman's Systems Model on intrapersonal stressors (Memmott *et al.* 2017: 58-73). Intrapersonal stressors relate to the response to stressful situations within the patient. This is the patient's defence mechanism in order to cope with having to wait for long periods at a time. Bademli and Duman (2017: 2) argued that stressful situations could likely create disequilibrium and cause disharmony, which ignites the patient's defence mechanisms to deal with the situation.

8.4 STRATEGIES USED TO IMPLEMENT PATIENT-CENTRED CARE FOR MENTAL HEALTH CARE USERS

Three sub-themes emerged while attempting to identify strategies that professional nurses used to implement PCC for MHCUs. These were holistic care, fast-tracking of MHCUs and screening of MHCUs. These sub-themes will be further explained as follows:

8.4.1 Holistic care

The majority of professional nurses perceived their care as being holistic as they provided all necessary care that the patient required, despite facing barriers mentioned earlier. Professional nurses considered all the needs of the MHCUs and did not necessarily concentrate only on their psychiatric illness. Once MHCUs were screened, they would be assessed by a psychiatric trained professional nurse and receive all necessary care in the same room. MHCUs would receive their psychiatric medication as well as medications related to their other medical conditions. It is crucial that nurses are able to integrate the appropriate skills, knowledge, judgement and values to ensure that holistic care is provided (Grant, Lines, Darbyshire and Parry 2017; Liu and Aungsuroch 2018; Byrne, Baldwin and Harvey 2020). The Neuman's System Model (Memmott *et al.* 2017: 58-73) promotes a holistic approach to dealing with mentally ill patients and guides nursing practices which includes physiological, psychological, socio-cultural, spiritual and developmental aspects of a person (Bademli and Duman 2017: 2).

A study by Rajabpour and Rayyani (2019: 1-7) proved that there was a correlation between patients' perceptions of holistic care and their contentment with the nursing care received. Holistic care was seen to be a part of the comprehensive care package that impacted on every aspect of a person as a whole. It is the patient's right to claim the best possible care from health care professionals. Nursing personnel should take heed of patients' opinions regarding holistic care to increase the quality and quantity of care provided. In the current study, professional nurses concurred that they tried their best to focus on the patient. Studies reveal that holistic care should be widely emphasised and included in the nursing curriculum or as ongoing education to ensure that quality nursing care is maintained (Jasemi, Valizadeh, Zamanzadeh and Keogh 2017; Rajabpour and Rayyani 2019).

8.4.2 Fast-tracking of MHCUs

Fast-tracking was a strategy that was used by professional nurses as they believed that this was a key factor in ensuring that the psychiatric clinic was effectively managed. Professional nurses took into consideration the MHCUs impatience, unstable temperament and the fact that MHCUs are very routine oriented. Once the MHCUs were screened, they followed a separate queue to that of the general chronic patients. Some facilities eliminated the screening queue altogether and screening was done by the same psychiatric nurse that attended to them. In this way, the MHCUs were fast-tracked to curb the waiting times.

Mahanta, Das and Dhar (2016: 363) mentioned that individuals are faced with having to queue in their daily lives, especially when it relates to visiting healthcare facilities. Although queuing is anticipated in most instances, it negatively impacts on patients' health and inevitably causes patients to become dissatisfied (Mahanta, Das and Dhar 2016: 363). In a study by Daniels, Zweigenthal and Reagon (2017: 98-102), it was reiterated that waiting in queues usually leads to patients becoming frustrated. Patients related the long waiting times to poor quality of service provided. The extended waiting times impacted negatively on patients who were already in poor health. One of the strategies to improve on the waiting times was similar to the current study, whereby fast-tracking of certain queues relieved the stress of more vulnerable patients. A change in the culture of an organisation resulted in nursing personnel being more cognisant of the impact that waiting times had on patients.

A South African study conducted by Sokhela, Makhanya, Sibiyi and Nokes (2013: 1-8) investigated health care user's experiences of the fast queue system. The fast queue was implemented to improve access to health care services for health care users. The results revealed two major themes, the flow of health care users and communication. The fast queue was perceived differently at the various facilities which were dependent on the

implementation at each facility. Health care users reported that the fast queue was an effective strategy if implemented correctly and did improve on their waiting times at the clinics. They further reported that open communication and sharing of information during the queuing process was important, otherwise, health care users became upset with the delays of the unknown.

Egbujie, Grimwood, Mothibi-Wabafor, Fatti, Tshabalala, Allie, Vilakazi and Oyeibanji (2018: 311-318) investigated the impact of the implementation of the ideal clinic on patient waiting times in PHC clinics in the Amajuba District, KZN. The ideal clinic model was implemented to strengthen the health system in South Africa and to reduce the amount of time that patients spent waiting in the clinic. The analysis showed that the total time spent in the clinic after the implementation of the ideal clinic was reduced. Facilities had improved when appointment registers were used effectively and impacted negatively when they were not. However, once patients arrived at the facility, the variations in the set-up of the different facilities impeded the flow of patients. They also reported that high patient numbers to low nurse ratios impacted on the time patients spent in the clinics. Another factor that contributed to the extended waiting times was absenteeism of staff due to various reasons. They concluded that proper planning regarding scheduling of staff leave was necessary in improving the patient waiting times. In the current study, staff shortages were reported as a barrier which impacted on the service delivery, as well as the bookings system of patients which was not specified according to certain time slots or the number of staff available to consult. MHCUs would queue as they arrived in the clinic and would wait to be consulted by a professional psychiatric nurse.

8.4.3 Screening of MHCUs

The findings of the current study revealed that the introduction of the screening process was not well received by MHCUs from the onset. Professional nurses were initially apprehensive as well but agreed that it promoted PCC. Their apprehensiveness was related to the uncertainty of how

the MHCUs would respond to the screening process. Despite the MHCUs unhappiness as they felt it was unnecessary, screening of MHCUs proved to be a favourable strategy in the holistic care of the patient. As frontline workers, nurses working in the PHC setting should be knowledgeable and equipped to incorporate screening of patients with chronic medical conditions and substance abuse (Timko, Kong, Vittorio and Cucciare 2016: 1-2). It is important for a comprehensive screening or workup to be done on any patient experiencing psychiatric symptoms to eliminate treatable co-morbidities, such as anaemia or hypothyroidism (Braitman 2018: 5).

A study by Spivak, Cullen, Eaton, Nugent, Rodriguez and Mojtabai (2018: 479-482) explored the association between the delays in seeking general medical care and individuals with serious mental illness. They found that about two-thirds of the participants reported a delay in seeking general medical care. The participants had regular medical visits to their healthcare facilities, yet it was not discussed. They further stated that it was important for healthcare workers to initiate routine health screening to identify any undetected medical conditions. Hlongwa and Sibiya (2019a: 4) stated that all patients in the PHC clinic were screened for mental illnesses and would be referred for further management by a psychiatric qualified nurse. These results support the findings of the current study, as professional nurses implemented the screening of all psychiatric patients which enabled them to identify any co-morbidities. The MHCUs would then be evaluated by the visiting Medical Officer and appropriate treatment initiated.

8.5 THE EXTENT TO WHICH MENTAL HEALTH HAS BEEN INTEGRATED INTO PRIMARY HEALTH CARE

In the current study, the extent to which mental health has been integrated into PHC was explored during the one-on-one interviews. Participants related the integration of services to the prescripts of the ideal clinic. Three sub-themes emerged relating to the impact of the integration of services. The sub-themes were prescripts of the ideal clinic, MHCUs temperament and

promoting nurse-patient relationships. The integration of mental health into PHC has been implemented in several countries worldwide (Barraclough, Longman and Barclay 2016; Schneider *et al.* 2016; Maconick *et al.* 2018). Additionally, researchers have reported on the barriers and facilitators related to the process of integration. Barriers were identified as the lack of human resources, a lack of in-service and education. Adequate mental health plans and policies as well as the availability of sufficient funds were viewed to be facilitators (Mugisha, Ssebunnya and Kigozi 2016; Wakida, Akena, Okello, Kinengyere, Kamoga, Mindra, Obua and Talib 2017; Rehman, Amjad, Minhas, Kamran and Shah 2019). According to Schneider *et al.* (2016: 157), the integration of mental health into PHC in South Africa has been sluggish due to a lack of knowledge of feasible, acceptable and effective collaborative care models.

Hlongwa and Sibiya (2019b: 1-9) conducted a study to determine the challenges affecting the implementation of the policy on the integration of mental health care into PHC in KZN, South Africa. The results revealed that PHC nurses lacked the appropriate skills in managing MHCUs as not all the nurses were trained psychiatric nurses. The PHC nurses further stated that they were not aware of the policy on the integration of mental health into PHC with some reporting being aware but had never actually seen the policy. There was a lack of communication between the management and the PHC nurses which left the nurses demotivated as relevant information was not shared with them.

8.5.1 Prescripts of the ideal clinic

In the current study, participants reported the integration process that was implemented appeared to be patient-centred, however it did not really work for psychiatric patients. Participants reported that the integration process went as far as the screening of patients. Professional nurses further argued that the health patients' registration system file, was not beneficial to psychiatric patients. This was the new book that was recommended for the

documentation of the nursing process. Professional nurses reported that there were insufficient provisions made in the book to comprehensively document the mental state and ongoing progress of MHCUs. Studies reveal that adequate documentation of the nursing process achieves a more comprehensive approach and supports the continuity of care for patients (Pérez Rivas, Martín-Iglesias, Pacheco del Cerro, Minguet Arenas, Garcia Lopez and Beamud Lagos 2016; De Groot, Triemstra, Paans and Francke 2019; Shoqirat, Mahasneh, Dardas, Singh and Khresheh 2019).

The Ideal Clinic Programme is an initiative of the South African National Department of Health and focuses on correcting the areas that are lacking in the PHC clinics. Integrated Clinical Services Management (ICSM) is a key focus area within the ideal clinic. It focuses on a health care service that delivers integrated services to patients with chronic and acute illnesses taking on a patient-centred focus. The health service delivery was re-organised into three streams, namely, maternal and child health, acute and chronic streams (South Africa. Department of Health 2018: 1).

8.5.2 MHCUs temperament

In the current study, participants reported that the integration of services was challenging due to the temperament of MHCUs. They argued that the temperament of MHCUs was erratic, as one minute they would be stable and the next minute they could present with psychotic symptoms. Participants acknowledged that MHCUs required stability and needed more attention than the general chronic patient. The application of the Neumans Systems Model (Mommott *et al.* 2017: 58-73) supports the current findings as participants identified that interventions had to be implemented to ensure that MHCUs visits to the clinic were stress-free and beneficial to their ongoing care.

There is a higher probability that people with mental disorders are at risk of agitation and violent behaviours than mentally well persons. These behaviours could be triggered by substance abuse, environmental stressors

as well as socio-economic status (Gaynes, Brown, Lux, Brownley, Van Dorn, Edlund, Coker-Schwimmer, Weber, Sheitman, Zarzar and Viswanathan 2017; Mauri, Cirnigliaro, Di Pace, Paletta, Reggiori, Altamura and Dell’Osso 2019). Stress is known to be a contributing factor to mental illness and can further exacerbate symptoms if untreated (Mannarini, Reikher, Shani and Shani-Zinovich 2017; Stolzenburg, Freitag, Evans-Lacko, Speerforck, Schmidt and Schomerus 2019). Neuman Systems Model (Memmott *et al.* 2017: 58-73) suggests three types of prevention, namely primary, secondary and tertiary. These levels of prevention allow the nurse to ensure wellness and stability with MHCUs. Primary prevention reduced the possibility of encounters with stress, secondary prevention was related to the treatment of symptoms and tertiary prevention empowered the nurse to prevent a recurrence and maintain stability.

8.5.3 Promoting nurse-patient relationships

Professional nurses in the current study argue that effective nurse-patient relationships are a core factor in promoting PCC. Participants admitted that MHCUs were very routine-oriented and were more compliant if they had a trusting relationship with professional nurses that cared for them. Due to the integration of services, the same professional nurses did not always remain in the psychiatric clinics. Professional nurses had to rotate between the different disciplines, and at first, MHCUs were very unhappy. The participants concurred that it was important for nurses to take the time to build a rapport with MHCUs and gain their trust ensuring quality nursing care. The current findings were consistent with other studies that revealed professional therapeutic interpersonal relationships are a fundamental component in mental health nursing with trust, empathy and respect being key elements (Heidke, Howie and Ferdous 2018; McAllister, Robert, Tsianakas and McCrae 2019; Alabd and Mohammed 2019).

According to Feo, Rasmussen, Wiechula, Conroy and Kitson (2017: 55), nurse-patient relationships extend far beyond just the nurse and the patient. It

is important to involve the entire MDT as well as the families of the MHCUs. In this way, care of the patient is consistent, as all stakeholders work towards a common goal, which is to ensure the well-being of the patient. In support of the findings of the current study, Feo *et al.* (2017: 56) argue that it is not always easy to ensure a solid nurse-patient relationship is built as this takes time. Nurses need to be innovative in creating opportunities and identifying strategies to overcome any barriers which may hinder effective nurse-patient relationships. Alabd and Mohammed (2019: 115) state that effective communication skills together with appropriate knowledge on nurse-patient relationships was essential to increase the quality of patient care. Provisions should also be made to obtain the patient's opinions on the quality of care received for improvements to be made. Furthermore, management should consider the nurse-patient ratios as well as the workload to allow for effective nurse-patient relationships to flourish (Alabd and Mohammed 2019: 115).

8.6 CHANGES PROPOSED TO ENHANCE PATIENT-CENTRED CARE

Participants contended that they always tried to give off their best and provide quality nursing care to promote PCC under the current circumstances. Professional nurses proposed changes in the following areas to further enhance their ability to provide effective PCC. The areas are lack of training, poor infrastructure, shortage of staff and lack of home visits.

8.6.1 Lack of training

Professional nurses agreed that change in the workplace was expected and they were keen on embracing the changes if they were better prepared. The majority reported that minimal information was received regarding the changes in the integration of services and the implementation of the prescripts of the ideal clinic. Participants argued that despite being psychiatric trained as well trained PHC nurses, the lack of formal, planned training prior to the implemented changes, made them feel helpless and frustrated. The results of the current study were consistent with the study by Hlongwa and Sibiya (2019b: 4-5) whose findings revealed that PHC nurses were not familiar with

the policy on the integration of mental health into primary health. They also reported a lack of the appropriate skills necessary for the management of MHCUs. Ram (2019: 91) reiterated that adequate knowledge in a particular subject matter will inevitably improve nurses' performance. Improved knowledge promotes positive attitude of nurses towards their patients.

A South African study conducted by Letlape, Koen, Coetzee and Koen (2014: 1-9) explored the in-service needs of psychiatric nurses. The broad themes that emerged in their study were consistent with the current study which found that ongoing in-service training was necessary to provide nurses with the appropriate knowledge and skills to improve on their abilities. Social, physical and psychological advantages would be gained as psychiatric nurses would be able to enhance their understanding and relate to others. It would further contribute to a decrease in patient or staff injuries, improve their confidence and moreover reduce their levels of stress and anxiety in the clinical setting. Participants in the current study proposed regular and updated in-service education on the current integration of services as well and any other proposed changes.

8.6.2 Poor infrastructure

In the current study, professional nurses expressed their unhappiness regarding the lack of space which in turn lead to a lack of privacy. Professional nurses reported that it was challenging to have open discussions with MHCUs as in some of the facilities, the same room was used by more than one healthcare provider at the same time. According to Hunter, Chandran, Asmall, Tucker, Ravhengani and Mokgalagadi (2017: 111), an ideal clinic is defined as a clinic with good infrastructure, which refers to the physical condition and spaces. As mentioned earlier, the ICSM programme was person-centred and was developed and implemented in response to the current deficiencies in the quality of primary health, yet according to the current study, this appears to be in contrast with the prescripts of the ideal clinic. A study done in Liberia by Gwaikolo, Kohrt and Cooper (2017: 8)

support the findings of the current study where poor physical infrastructure of mental health facilities and a lack of space resulted in a lack of privacy during patient consultations. Hlongwa and Sibiya (2019b: 6) reiterate that privacy is an essential factor in ensuring confidentiality between nurses and MHCUs during their consultation.

Hunter *et al.* (2017: 117) state that the re-organisation of the facilities in line with the ideal clinic has been inadequate and inappropriate. According to their analysis of the improvements in the infrastructure, the compliance improved from 13% to 28%, which was in no way close to the required capacity or size as proposed. In the current study, participants were faced with trying their best to implement the new initiative with the current infrastructure that was in place. Professional nurses, therefore, proposed improved infrastructure of their current facilities, which would be according to the guidelines of the integration of services.

8.6.3 Shortage of staff

Professional nurses in the current study maintain that they had many patients that they consulted with daily despite the ongoing problem of staff shortages. They further expressed that adequate staffing at their facilities will help relieve the pressure placed on them to ensure that all patients were nursed holistically. More staff would allow professional nurses to dedicate more time to MHCUs and ensure care is tailored and patient centred. The problem of staff shortages was supported by other studies where a lack of nurses has been reported worldwide (Hatamizadeh, Hosseine, Bernstein and Ranjbar 2018; Nesengani, Downing, Poggenpoel and Stein 2019; Marć, Bartosiewicz, Burzyńska, Chmiel and Januszewicz 2019). Nesengani *et al.* (2019: 1-11) reported that the shortage of nurses in community clinics discouraged nurses as they were still expected to continue with their daily duties. There were no provisions made for reducing the staff shortages along with the allocated workload.

Marć *et al.* (2019: 9-16) report that there is a huge concern regarding shortages of nurses both nationally and internationally. It is imperative that strategies must be explored to make nursing a more lucrative profession. It was suggested that qualifications should be appropriately remunerated which will further encourage nurses to improve on their skills and feel appreciated. Matlala and Lumadi (2019: 4) share similar findings by stating that nurses felt demoralised by the chronic shortage of staff which caused low morale and burnout. Nurses reported feeling overwhelmed at times with the workload, despite being aware that the staff shortages were countrywide. The professional nurses in the current study, therefore proposed more psychiatric trained nurses to be employed at their facilities.

8.6.4 Lack of home visits

Professional nurses in the current study reported their concern regarding the lack of home visits following the integration of services. According to the participants, home visits are crucial in the ongoing monitoring and evaluation of MHCUs. They stated that mentally ill patients were different from the general medical chronic patients. MHCUs lacked a degree of insight and needed ongoing support and guidance. Professional nurses argued that previously if patients defaulted on their clinic visits, they would arrange a home visit to investigate the reasons to prevent defaulting in their medication as well as possible relapse and re-admission to hospital. They further stated that it allowed them to assess the MHCUs living conditions and the opportunity to speak to the MHCUs family members.

A study by Jackson, Kasper, Williams and DuBard (2016: 163-171) supports the sentiments of professional nurses in the current study. They found that patients who received a home visit from a healthcare professional decreased the re-admission rates by half. Home visits appeared to be beneficial with patients who were at a higher risk of re-admission (Jackson *et al.* 2016; Klug, Gallunder, Hermann, Singer and Schulter 2019). An array of services may be provided during the home visits, which include health education, medication

review, education and identification of any social or environmental barriers (Jackson *et al.* 2016: 168).

A more recent study done in Japan by Iwasaki, Hirai, Kageyama, Satoh, Fukuda, Kai, Makino, Magilvy and Murashima (2018: 557-563) evaluated all undergraduate nursing students who were tasked to conduct home visits monthly or bi-monthly to elderly patients over the age of 75 years for one year. During the home visits nurses talked to the elderly to understand their physical, mental and psychosocial conditions. They took into consideration preventative measures against prevalent diseases and illnesses and provided the appropriate care plans for each patient. Topics of discussions were about the patients' life, history, hobbies, diet, exercise and any other concerns that patients or nurses brought up. At the end of their evaluation, students reported acquiring various ways in understanding and assessing the elderly as home visits proved to vastly widen their knowledge and experience. In the current study, professional nurses shared the same sentiments as the participants in the above study regarding the benefits of home visits. They expressed strong viewpoints that home visits were an essential component in the care of all patients especially MHCUs. They advocated that home visits should resume as it was in line with PCC.

8.7 SUMMARY OF THE CHAPTER

This chapter discussed the findings that were presented in the previous three chapters. The discussions of the findings were based on the themes and sub-themes that emerged during the analysis and were discussed in conjunction with the research objectives and the conceptual framework that underpinned this study. The following chapter will discuss the proposed guidelines to enhance PCC in community psychiatric clinics.

CHAPTER 9: PROPOSED GUIDELINES TO ENHANCE PATIENT-CENTRED CARE FOR MHCUs IN COMMUNITY PSYCHIATRIC CLINICS

9.1 INTRODUCTION

The previous chapter presented the discussion of the results in relation to the study objectives and the theoretical framework and the Neumans Systems Model, which guided this study. Guidelines have a variety of purposes and generally aims to improve quality patient care and assists health care workers to eliminate adverse events (Shekelle, Woolf, Grimshaw, Schünemann and Eccles 2012; Kredo, Bernhardsson, Machingaidse, Young, Louw, Ochodo and Grimmer 2016; Prentice, Moore, Crawford, Lankshear and Limoges 2020). This chapter presents the proposed guidelines to enhance PCC for MHCUs in community psychiatric clinics, which was a part of the overall aim of the study and the fifth and final objective.

9.2 THE PROCESS IN THE DEVELOPMENT OF THE GUIDELINES

The development of the proposed guidelines was based on the findings of the current study which were achieved through the first four objectives and the research questions that were asked during the interview process. The objectives of the study were to:

- Explore nurses' understanding of PCC at community psychiatric clinics.
- Identify barriers that prevent the successful implementation of PCC when caring for MHCUs.
- Identify the strategies used to implement PCC for MHCUs.
- Explore the extent to which mental health care has been integrated into PHC.
- Identify changes proposed by participants in order to enhance PCC.

The themes and sub-themes that emerged from the objectives that guided this study were used in the development of the proposed guidelines. Developed guidelines should be subjected to external reviews to ensure content validity, clarity and applicability (Shekelle *et al.* 1999: 351). Therefore, the current proposed guidelines were reviewed by experts in the relevant field as well as the end-users of the proposed guidelines.

The following steps by Shekelle *et al.* (1999: 348-351) were considered in the development of the proposed guidelines:

- Identifying and refining the subject area.
- Selecting and running guideline groups.
- Identifying and assessing the evidence in relation to a literature review.
- Translating evidence into proposed guidelines.
- Subjecting the proposed guidelines to expert reviewers.

9.3 SCOPE OF THE GUIDELINES

The proposed guidelines are recommended specifically for operational managers, professional nurses and MHCUs in community psychiatric clinics. The guidelines have been adapted in conjunction with the results of the current study, and therefore will be applicable to the community psychiatric clinic setting. Guidelines are based on research and scientific evidence in a specific field, although they should not supersede professional judgement (Rosenfeld and Shiffman 2009: 7).

9.4 PURPOSE OF THE PROPOSED GUIDELINES

The purpose of the proposed guidelines serves to assist operational managers and professional nurses to further enhance PCC for MHCUs in community psychiatric clinics. In line with the components of PCC, guidelines for MHCUs were also included. This enables MHCUs to be a part of their personal care and treatment, empowering them with a sense of autonomy. The guidelines were formulated bearing in mind that not all the suggested changes could be incorporated. Careful thought was given to how all the

relevant stakeholders could work together towards achieving PCC for MHCUs. These guidelines may prove beneficial to healthcare workers who are new to community psychiatric clinic settings as well as existing staff. The purpose is to ensure that quality PCC is provided and maintained.

9.5 RATIONALE FOR THE PROPOSED GUIDELINES

The overall aim of this study was to identify the extent to which mental health has been integrated into the general health stream and ultimately to develop guidelines to enhance PCC for MHCUs in community psychiatric clinics. It was important to identify the above to determine how the integration of services correlated to MHCUs and PCC. It was evident from the results that the integration process did impact on PCC. Hence, these guidelines aim to assist the stakeholders to persevere with providing PCC together with the implemented changes. The active involvement of patients in the planning of their care has gained salience in healthcare settings (Greene, Tuzzio and Cherkin 2012; Van Dulmen, Lukersmith, Muxlow, Santa Mina, Nijhuis-van der Sanden, van der Wees and Allied Health Steering Group 2015; Naldemirci, Wolf, Elam, Lydahl, Moore and Britten 2017). Hence, MHCUs have been included in the proposed guidelines to contribute to their care in line with their needs. It is imperative to constantly evaluate the care provided to ensure that the standard of care is maintained, therefore, the formulation of these guidelines is necessary to ensure quality PCC is always delivered.

9.6 RECOMMENDED GUIDELINES

According to the WHO (2012: 48), recommended guidelines should be clear and actionable. The proposed guidelines were recommended for operational managers, professional nurses and MHCUs. A summary of the proposed guidelines is presented in Figure 9.1.

9.6.1 Recommended guidelines for operational managers

The operational managers at the community psychiatric clinics are responsible for the smooth running of the overall clinic. They are tasked with a huge responsibility of ensuring that the needs of the MHCUs and the staff are met. The operational managers are also in a position of authority to promote effective change to improve PCC. Operational managers play a vital role in health care (Adriaenssens, Hamelink and Van Bogaert 2017: 85). They have the vast responsibility to ensure that quality patient care is achieved (Oosthuizen-Van Tonder, du Preez and Bester 2019: 402). The implementation of the guidelines by operational managers will further enhance PCC in community psychiatric clinics.

9.6.2 Recommended guidelines for professional nurses

The professional nurses in the current study were the frontline workers who were in direct contact with MHCUs daily. The results revealed that they were faced with many challenges with the integration of services and how these challenges impacted on PCC. The proposed guidelines attempt to assist professional nurses to be better equipped to provide PCC for MHCUs.

9.6.3 Recommended guidelines for MHCUs

The MHCUs were not included in the study sample, although the results of the study directly impacted on them as well as the care received. The concept of PCC would be meaningless without the inclusion of MHCUs. It was therefore important to include the MHCUs in the recommended guidelines. The guidelines intend to allow the MHCUs to play a more active role in their care and further empowering them with appropriate skills and knowledge to better understand the processes and changes in healthcare.

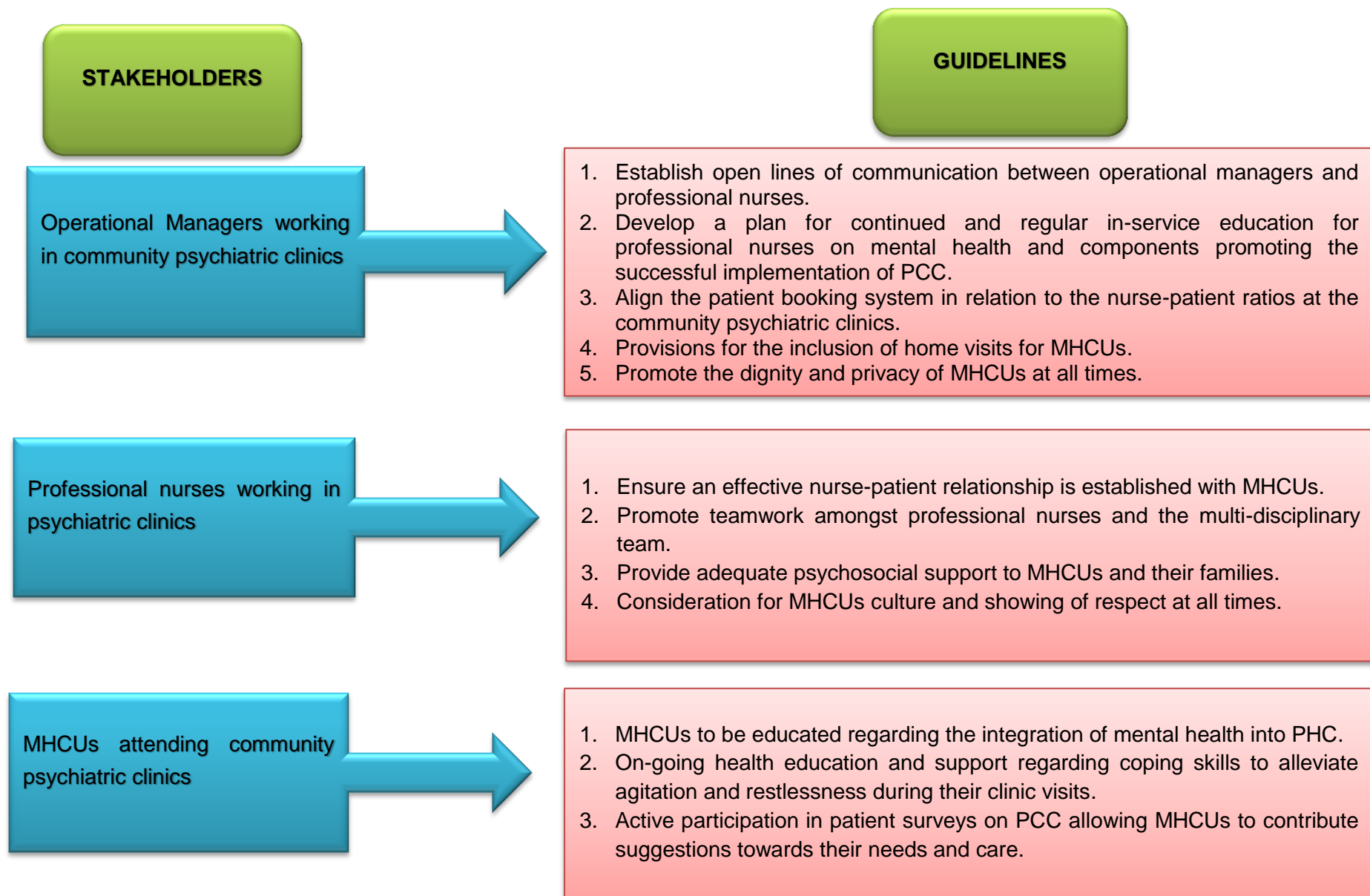


Figure 9.1: Proposed guidelines to enhance PCC for MHCUs in community psychiatric clinics

9.7 PROPOSED GUIDELINES FOR OPERATIONAL MANAGERS IN COMMUNITY PSYCHIATRIC CLINICS

The guidelines below were recommended for operational managers in the community psychiatric clinics as they hold the authority and leadership to effectively initiate the following guidelines. It is the prerogative of the operational managers to ensure that the community psychiatric clinics are managed efficiently and quality patient care is provided. The proposed guidelines aim to assist operational managers to achieve their goals related to PCC. Managers have the responsibility to support individual and joint efforts of staff to ensure that the overall goals of the healthcare services are met (Folkman, Tveit and Sverdrup 2019: 97).

9.7.1 Guideline 1: Establish open lines of communication between operational managers and professional nurses

It is imperative to have open lines of communication in the community psychiatric clinics between operational managers and professional nurses. This guideline was directed to the operational managers as it is a part of the leadership and corporate governance domain for senior management according to the NCS (South Africa. Department of Health 2011). Clear lines of communication should be established to effectively implement changes in community psychiatric clinics. Regular and on-going communication regarding changes in the community psychiatric clinics should be filtered to professional nurses. Professional nurses should be able to approach the operational managers to clarify and obtain clear guidelines on any new changes or concerns in the workplace. This guideline was developed as professional nurses reported not being adequately informed of proposed changes in the psychiatric clinic.

Recommendations

- Promote open communication between operational managers and professional nurses.
- Establish a communication book to be used to ensure that the chain of communication is not broken.
- Regular meetings between operational managers and professional nurses to promote openness.
- Operational managers to avail themselves timeously and be open to suggestions or concerns raised.
- Ensure that the lines of communication are clearly stated and displayed to promote transparency.

Rationale

Open two-way communication will promote professional nurses to effectively implement and promote changes. Jardien-Baboo *et al.* (2016: 404) reiterate that managers should be aware of the leadership styles that they project, ensuring that they foster a milieu of open communication and a positive working environment to promote PCC. If professional nurses understand the reasons for changes or interventions, they will be more willing to implement the changes.

9.7.2 Guideline 2: Develop a plan for continued and regular in-service education for professional nurses on mental health and components promoting the successful implementation of PCC

A programme should be drawn up in consultation with the professional nurses regarding their educational needs and required updates. This planned programme entailing topics for regular in-service education should be available to all professional nurses. A regular in-service programme will allow professional nurses to keep up to date with information related to improving the quality of nursing care in line with the NCS. Clinical competence is based on the theoretical and practical skills that nurses are required to possess to provide efficient patient care. In order to achieve a positive result, clinical

competencies should routinely be assessed (Prentice *et al.* 2020: 4). In addition, Jardien-Baboo *et al.* (2016: 402) state that patients are evolving constantly and therefore ongoing education should be ensured.

Recommendations

- Obtain a baseline assessment of professional nurses' knowledge regarding PCC.
- Professional nurses should be familiar with the clinical competencies for mental health nursing.
- Create a positive learning environment to promote learning.
- Make use of learning opportunities in the clinical setting.
- Ensure a structured, written programme is available to all professional nurses.
- Allow professional nurses to make contributions to the content of the programme.
- A register should be kept to record proof of in-services provided and attended.

Rationale

Nurses should ensure that their knowledge is up to date to deliver expert care (Moetsana-Poka, Lehana, Lebaka and McCarthy 2014: 10). Continuous professional development is seen as a key element to improve the standards of healthcare in the sub-Saharan African region (Moetsana-Poka *et al.* 2014; Feldacker, Pintye, Jacob, Chung, Middleton, Iliffe and Kim 2017).

9.7.3 Guideline 3: Align the patient booking system in relation to the nurse-patient ratios at the community psychiatric clinics

The booking of MHCUs should be done in conjunction with the number of professional nurses that are available to consult with patients. If bookings are done according to staggered appointment times, this may assist to reduce the waiting times of MHCUs. It could also prevent long queues allowing

professional nurses to dedicate more time to provide holistic PCC. An effective booking system could alleviate the strain caused by staff shortages.

Recommendations

- Create a database of MHCUs that attend the community psychiatric clinic on a monthly basis.
- Ensure that all MHCUs receive an appointment date accordingly.
- Book appointments for MHCUs according to allocated timeslots.
- Ensure that the number of patients booked for the day complement the number of professional nurses on duty.
- Create a short message system (SMS) to be used as a reminder to MHCUs to confirm their appointments.

Rationale

Ensuring that health care facilities have adequate nurses is a huge challenge therefore reducing the number of booked patients to available nurse ratios serves as an attempt to alleviate the stress and strain placed on nursing staff (Yankovic and Green 2011: 942). Nappo and Ross (2019: 63) concur that ensuring specific appointment times minimised the waiting times for patients and potentially motivated patients to remain calm and wait for their treatment.

9.7.4 Guideline 4: Provisions for the inclusion of home visits for MHCUs

A submission for home visits to be included in the clinic routine may provide a more comprehensive approach to be adopted towards MHCUs. Home visits may improve nurse-patient relationships and allow professional nurses to effectively monitor and evaluate the progress of MHCUs in their home setting. Home visits are directly related to PCC, as it encompasses the person as an individual entity. Home visits further instil a sense of importance to the MHCUs.

Recommendations

- Compile a register for MHCUs that require home visits.
- Create a roster for professional nurses on a rotational basis.
- Formulate objectives to be achieved during the home visit.
- Ensure that MHCUs are aware of the dates and times of the home visits.
- Document all observations and interventions implemented along with necessary follow up visits.

Rationale

Conducting home visits allow professional nurses to maintain regular contact with MHCUs and promotes early detection of psychosocial and family problems. Home visits allow professional nurses to interact with MHCUs in a setting that is familiar to them promoting PCC.

9.7.5 Guideline 5: Promote the dignity and privacy of MHCUs at all times

Professional nurses in the current study uphold that the dignity and privacy of MHCUs should be ensured at all times. This appeared to be a situation that was not in their scope of practice to change. It was therefore aimed at the operational managers as they possessed the necessary authority to engage with the relevant stakeholders to facilitate the required changes. Due to the poor infrastructure of the majority of the psychiatric facilities, lack of space was a pressing challenge. The lack of space resulted in various members of the MDT consulting in the same room at the same time. This is in direct contravention of PCC. Motivations should be made by operational managers to the relevant authorities to provide better infrastructure to promote the dignity and privacy of MHCUs.

Recommendations

- A submission to be made for the improvements in the infrastructure of the psychiatric clinics. On the short term, park homes could be procured while plans could be started for the new buildings to be added on in the long term.
- The erection of temporary partitions in consulting rooms to provide privacy in the interim.
- Negotiate with other members of the MDT to alternate rooms to maintain privacy.
- Make use of mobile screens to promote the privacy and dignity of MHCUs.

Rationale

The human dignity and privacy of every MHCU must be respected (Republic of South Africa 2002). The aesthetics of the infrastructure are essential factors that impact on patient satisfaction in the delivery of healthcare (Hussain, Asif, Jameel, Hwang, Sahito and Kanwel 2019: 3719).

Table 9.1 provides a summary of the proposed guidelines related to the emerging themes and results recommended for operational managers.

Table 9.1: Proposed guidelines related to the emerging themes and results recommended for operational managers

Themes	Proposed guidelines
Components essential for the successful delivery of PCC.	<ul style="list-style-type: none"> • Establish open lines of communication between operational managers and professional nurses. • Develop a plan for continued and regular in-service education for professional nurses on mental health and components promoting the successful implementation of PCC.
Barriers that prevent the successful implementation of PCC.	<ul style="list-style-type: none"> • Align the patient booking system with the nurse-patient ratios at the community psychiatric clinics.
Changes proposed to enhance PCC.	<ul style="list-style-type: none"> • Provisions for the inclusion of home visits for MHCUs.
Poor infrastructure.	<ul style="list-style-type: none"> • Promote the dignity and privacy of MHCUs at all times.

9.8 GUIDELINES FOR PROFESSIONAL NURSES WORKING IN COMMUNITY PSYCHIATRIC CLINICS

The following guidelines were aimed at the professional nurses as they were in direct consultation with MHCUs daily. The results of the study also revealed that professional nurses were eager to provide quality nursing care to MHCUs, provided they were fully equipped to do so. These guidelines will assist professional nurses to build a rapport with MHCUs and gain their trust and understanding to ultimately ensure PCC is achieved.

9.8.1 Guideline 1: Ensure an effective nurse-patient relationship is established with MHCUs

To motivate MHCUs to be actively involved in their care and rehabilitation, effective nurse-patient relationships are necessary. Ensuring trusting relationships may encourage MHCUs to keep to their appointment dates, improve medication compliance and assist in preventing a relapse in their care. Thibeault (2016:1) finds that nurses forge a therapeutic relationship with

MHCUs with the intention of creating eloquent, future long-standing encounters.

Recommendations

- Build a rapport with MHCUs and gain their trust.
- Ensure a conducive environment is created to promote the formation of a therapeutic nurse-patient relationship.
- Ensure that MHCUs are aware that professional relationships are based on trust, respect, honesty and open communication.

Rationale

Effective nurse-patient relationships promote PCC. Healthcare professionals should never lose focus that the patient should always be at the epicentre in PCC (Frakking, Michaels, Orbell-Smith and Le Ray 2020: 6).

9.8.2 Guideline 2: Promote teamwork amongst professional nurses and the multi-disciplinary team

In the current study, professional nurses reported that teamwork was a vital component of PCC. Professional nurses should be encouraged to work together taking into consideration the issues of staff shortages. If duties are adequately shared and professional nurses are open to working together towards a common goal, it would improve the morale of their working environment. Inter-professional collaboration builds rapport between members of the healthcare teams and has the potential to give rise to new skills and competencies. Furthermore, professional nurses should be familiar with the policies and scope of practice for all categories of staff to promote understanding of each one's roles and scope of practice (Prentice *et al.* 2020: 5). This will clear any misconceptions and promote teamwork between all categories of staff.

Recommendations

- Professional nurse to have good knowledge of policies, procedures and scope of practices of all categories of staff.
- Ensure that a duty roster is drawn up so that professional nurses rotate and experience working with all staff.
- Promote open communication and effective use of interpersonal skills.

Rationale

Operational inter-professional teamwork in healthcare settings is associated with a more positive patient outcome promoting PCC and a more therapeutic working environment (Cutler *et al.* 2018: 68).

9.8.3 Guideline 3: Provide adequate psychosocial support to MHCUs and their families

A patient-centred approach promotes holistic care, it is therefore important for professional nurses to consider the psychological and social aspects when caring for MHCUs. Due to the MHCUs impaired insight, the inclusion of their families is required. Professional nurses need to ensure that the families of the MHCUs are aware of their health and progress. Psychosocial support will further promote the MHCUs to be included in their care and remain motivated towards rehabilitation. Once a proper assessment of needs is completed, MHCUs could be included in programmes to develop their psychosocial skills in the community. Frakking *et al.* (2020: 1) argue that there should be equal opportunities for patients and families to be active participants in their health care. Inter-collaboration between patients, families and healthcare workers should always be encouraged.

Recommendations

- Provide non-discriminatory psychosocial support to all MHCUs.
- Identify the psychological, physical and social deficits of MHCUs.

- Plan, implement and evaluate interventions based on individual deficits.
- Document the outcomes for further evaluation and continuity of care.

Rationale

Policies and programmes aimed at promoting the mental health status of a person must be implemented with regard to the mental capacity of the person concerned (Republic of South Africa. 2002). Therefore, MHCUs should be regularly assessed so appropriate interventions can be implemented.

9.8.4 Guideline 4: Consideration for MHCUs culture and showing of respect at all times

Professional nurses reported that considering the MHCUs culture and showing respect are important components in promoting PCC. Jardien-Baboo *et al.* (2016: 401) suggest that treating patients with love and respect was indeed a part of holistic PCC. Truong, Gibbs, Paradies and Priest (2017: 40) state that health care workers should make the effort to learn about different cultures to decrease the inclination to stereotype patients based on their race, culture or religion. It is important to understand how health care workers make allowances for racial and or ethnic cultures, which could promote the development of guidelines and interventions in relation to cultural competence (Truong *et al.* 2017: 41).

Recommendations

- Encourage open communication for MCHUs to express their feelings and concerns about their cultural beliefs.
- Actively listen to MHCUs to instil feelings of being valued, promote their self-worth and a sense of control in their care and treatment.
- Take MHCUs culture into consideration when implementing intervention related to their care.

Rationale

Cultural competence allows an individual to be sensitive and embraces the idea of learning new cultures of other individuals which promote improved health care, satisfaction and adherence to treatment (Henderson, Horne, Hills and Kendall 2018: 18). Therefore, it is imperative that professional nurses take cognisance of MHCUs culture and beliefs.

A summary of the proposed guidelines related to the emerging themes and results recommended for professional nurses are presented in Table 9.2

Table 9.2: Proposed guidelines related to the emerging themes and results recommended for professional nurses

Themes	Proposed guidelines
Components essential for the successful delivery of PCC.	<ul style="list-style-type: none">• Ensure an effective nurse-patient relationship is established with MHCUs.
Nurse's understanding of PCC.	<ul style="list-style-type: none">• Promote teamwork amongst professional nurses and the multi-disciplinary team.
Holistic care.	<ul style="list-style-type: none">• Provide adequate psychosocial support to MHCUs and their families.
Poor infrastructure.	<ul style="list-style-type: none">• Consideration for MHCUs culture and showing of respect at all times.

9.9 GUIDELINES FOR MENTAL HEALTH CARE USERS ATTENDING COMMUNITY PSYCHIATRIC CLINICS

The following guidelines were recommended for MHCUs, as it is important for them to be kept up to date with changes that affect their health and well-being. According to Rosenfeld and Shiffman (2009: 5), guidelines are beneficial to MHCUs, promoting positive outcomes, less negative incidences and more consistent patient care. Information on the guidelines could be disseminated in the form of pamphlets, posters and even videos played in the waiting areas of clinics.

9.9.1 Guideline 1: MHCUs to be educated regarding the integration of mental health into PHC

According to professional nurses in the current study, they reported that MHCUs were not completely compliant with the integration of services and the prescripts of the ideal clinic. Professional nurses need to take cognisance of this. MHCUs will be more understanding if they are aware of the changes and the benefits. Adequate knowledge may promote MHCUs to feel valued that they are being informed of the changes instead of being forced into complying with the unknown.

Recommendations

- Educate MHCUs on the integration of services and the prescripts of the ideal clinic.
- Ensure policies on the integration of mental health into PHC are adequately displayed in waiting areas and consultation rooms.
- Make provisions for questions and answer sessions to clear any misconceptions.
- Display posters on frequently asked questions so MHCUs can access at any time.

Rationale

Provisions should be made for the integration of mental health into the general health services environment (Republic of South Africa. 2002). It is therefore with austerity that professional nurses empower MHCUs with relevant knowledge. Ongoing health education and learning from health care workers as well as patients' experiences are vital in improving care in organisations (Frakking *et al.* 2020: 4). The more information patients obtain regarding their care, the greater the patient satisfaction and compliance to treatment (Hussain *et al.* 2019: 3719).

9.9.2 Guideline 2: On-going health education and support regarding coping skills to alleviate agitation and restlessness during MHCUs clinic visits

Positive reinforcements and on-going health education empower MHCUs with skills to deal with their daily stressors. It was reported in the current study that MHCUs became very restless and agitated if they had to wait for long periods at a time. This time could be utilised to provide ongoing support and education to equip MHCUs with effective coping skills. Utilising the waiting time could alleviate boredom, encourage MHCUs to learn new skills and prevent their restlessness and agitation.

Recommendations

- Plan, implement and evaluate cognitive behaviour therapy for relevant patients.
- Teach appropriate coping skills and stress management techniques.
- Promote MHCUs to actively participate in the proposed health education.

Rationale

Every MHCU must be provided with care, treatment and rehabilitation services that improve the mental capacity of the user to develop to full potential and to facilitate his or her integration into community life (Republic of South Africa. 2002). Effective psychosocial skills training promotes the development of improved functioning and supports effective rehabilitation in mentally ill persons (Sorour *et al.* 2014; Morin and Franck 2017).

9.9.3 Guideline 3: Active participation in patient surveys on PCC allowing MHCUs to contribute suggestions towards their needs and care

To provide quality nursing care, all stakeholders must be involved in providing feedback on the services rendered. MHCUs should be encouraged to

participate in patient surveys on PCC, to obtain valuable feedback on the care provided. MHCUs could remain anonymous to prevent victimisation and allowing honest feedback.

Recommendations

- Promote regular participation inpatient surveys regarding PCC.
- Ensure surveys are bilingual to encourage maximum participation.
- Make use of suggestion boxes at strategic points in the clinic to allow MHCUs to post anonymous suggestions.
- Ensure relevant posters, rights of the MHCUs, pamphlets, relevant policies and procedures are displayed.

Rationale

Promote the rights and interests of MHCUs that contribute to the improvement in their mental health status (Republic of South Africa. 2002) by allowing MHCUs to participate in surveys that may improve their care and rehabilitation.

The proposed guidelines related to the emerging themes and results recommended for MHCUs is summarised in Table 9.3

Table 9.3: Proposed guidelines related to the emerging themes and results recommended for MHCUs

Themes	Proposed guidelines
Prescripts of the ideal clinic	<ul style="list-style-type: none"> • MHCUs to be educated regarding the integration of mental health into PHC.
MHCU's temperament	<ul style="list-style-type: none"> • On-going health education and support regarding coping skills to alleviate agitation and restlessness during their clinic visits.
Holistic care	<ul style="list-style-type: none"> • Active participation in patient surveys on PCC allowing MHCUs to contribute suggestions towards their needs and care.

9.10 EVALUATION OF PROPOSED GUIDELINES

The current guidelines were reviewed by experts involved in developing guidelines as well as potential users of the guidelines. Guidelines should be subjected to review and evaluation to assess for content validity, clarity and applicability. Three areas should be covered in the evaluation: experts in the field to review and validate the literature review; systematic reviewers who will assess the techniques used in the development of the guidelines and the future users of the guidelines to evaluate its user-friendliness and relevance. Guidelines should be studied and restructured as new, relevant evidence is available (Shekelle *et al.* 1999: 351). In addition, the WHO (2012: 55) recommended that evaluation of performance measures should be in line with the following:

- Dissemination of guidelines.
- Potential change in practice performance.
- Possible changes in health outcomes.
- Alterations in the end-users understanding and knowledge.
- Consequences related to economic change.

9.10.1 Evaluation by experts

Five experts evaluated the proposed guidelines and the feedback is presented Table 9.4.

Table 9.4: Feedback from experts on the proposed guidelines

Experts	Feedback
Expert 1	Guidelines are: <ul style="list-style-type: none">• Are clear and actionable.• Target the relevant stakeholders such as the patient and the service provider.• May enhance patient-centred care at an operational level.• Empowers mental health care users and encourages them to play an active role in planning their care.• Plays a vital role in quality improvement and quality assurance processes at an operational level.
Expert 2	Guidelines are: <ul style="list-style-type: none">• Valid as they were based on the research findings.• Reliable and may yield similar results if applied to different practitioners.• Applicable to the relevant stakeholders.• Short, clear and to the point.• The development of these guidelines is highly recommended.
Expert 3	<ul style="list-style-type: none">• Guidelines are relevant for a new operational manager entering the PHC setting and dealing with MHCUs.
Expert 4	<ul style="list-style-type: none">• The content is relevant and appropriate with regards to PCC in community psychiatric clinics.• The information will serve as valuable guidelines for the stakeholders.• The content reflects the importance of the involvement of the MDT.
Expert 5	<ul style="list-style-type: none">• The content is logical and clear.• The information is relevant and applicable to the relevant stakeholders.

Attributes of good practice guidelines is presented in Table 9.5

Table 9.5: Attributes of good practice guidelines (Panteli, Legido-Quigley, Reichebner, Ollenschläger, Schäfer and Busse 2019: 239)

Attributes	Applicability to the proposed guidelines
Validity	Practice guidelines should be evidence-based. Recommendations were based on the research findings and a literature review.
Reliability	Guidelines should be reliable and produce the same results when applied by different practitioners. These guidelines were developed for application in community psychiatric clinic settings.
Clinical Applicability	Guidelines should be aimed at a specific population. The proposed guidelines apply to the relevant stakeholders mentioned in the study as they are directly involved in PCC.
Clarity	Guidelines should be unambiguous. Guidelines were therefore short, clear and to the point.
Multidisciplinary process	The proposed guidelines were reviewed by external reviewers in the relevant field of study as well as the end-users.
Clinical flexibility	Guidelines were developed based on the specific subject area based on the study results.
Scheduled review	Reviews will be based on any new emerging evidence related to the guideline content.
Documentation	Documentation of relevant literature review was ensured.

9.11 DISSEMINATION OF THE PROPOSED GUIDELINES

The guidelines will be disseminated to the relevant stakeholders mentioned in the guidelines; operational managers, professional nurses and MHCUs at the community psychiatric clinics. Hard and soft copies of the thesis will be accessible through the DUT library. Research papers will be published online and presented at various platforms and could also be incorporated into the nursing curriculum. According to the WHO (2012: 51), the dissemination of guidelines ensures that the recommended guidelines are shared with a variety of audiences. Guidelines could also be translated into different languages to benefit audiences worldwide.

9.12 SUMMARY OF THE CHAPTER

Chapter 9 presented proposed guidelines to enhance PCC for MHCUs in community psychiatric clinics. The guidelines were based on the results of the study and were aimed to guide operational managers, professional nurses and MHCUs at community psychiatric clinics. Chapter 10 entails the conclusion, recommendations and limitations of the study.

CHAPTER 10: CONCLUSION, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY

10.1 INTRODUCTION

Chapter 9 presented the proposed guidelines to enhance PCC for MHCUs in community psychiatric clinics. The chapter also included discussions on the process, scope, purpose and rationale of the developed guidelines. Chapter 10 includes the conclusion, recommendations and limitations of the study.

10.2 CONCLUSION OF THE STUDY

The current study was conducted in the uMgungundlovu district, KZN at three CHCs and three PHC clinics that offer psychiatric services to MHCUs. The sample included the operational managers in charge of the psychiatric facilities and professional nurses who were in direct contact with MHCUs daily. The Neuman's Systems Model together with the findings of the first four objectives guided the development of the proposed guidelines. The proposed guidelines focused on enhancing PCC and were proposed to be implemented in community psychiatric settings by the operational managers, professional nurses and MHCUs in the uMgungundlovu district, KZN.

10.2.1 Realisation of the study aim

The aim of this study was to identify the extent to which mental health has been integrated into the general health stream and ultimately develop guidelines to enhance PCC for MHCUs in community psychiatric clinics in the uMgungundlovu District, KZN. The aim was achieved through the three phases of data collection, namely; observation (Phase 1), survey questionnaires (Phase 2) and one on one interviews (phase three). The themes and sub-themes that were identified in phase two and three assisted in achieving the aim of the study. The extent to which mental health has been

integrated into PHC was discussed in chapter 8. Participants reported that the policy on the integration of services was implemented, although the desired outcome was not achieved due to challenges experienced. Based on the themes and sub-themes that emerged together with the conceptual framework that underpinned this study, guidelines were proposed in Chapter 9.

10.2.2 Realisation of the study objectives

The objectives of the study were to:

- Explore nurses understanding of PCC at community psychiatric clinics.
- Identify barriers that prevent the successful implementation of PCC when caring for MHCUs.
- Identify the strategies used to implement PCC for MHCUs.
- Explore the extent to which mental health care has been integrated into PHC.
- Develop guidelines to enhance PCC for MHCUs.

The objectives were achieved by merging the findings from the observation, quantitative and qualitative phases. The analysis of the findings from the observation and quantitative phases were authenticated during the qualitative phase. Triangulation refers to the utilisation of various sources converging to draw conclusions (Polit and Beck 2010: 115). Data from all three phases contributed towards achieving the study objectives. The realisation of the four objectives together with the Neumans Systems Model, led to the accomplishment of the fifth and final objective which was to develop guidelines to enhance PCC for MHCUs.

10.3 RECOMMENDATIONS

The proposed recommendations were based on the findings that were discussed in chapter 8. Ultimately, it will be the responsibility of the operational managers at the psychiatric facilities to ensure that the proposed guidelines are effectively implemented. The recommendations for the use of

the proposed guidelines are aimed at the operational managers and professional nurses. The proposed guidelines for the MHCUs will be spear-headed by the nursing staff who will be responsible to steer the MHCUs towards their active participation in the guidelines to ensure that PCC is enhanced. Ensuring a safe and therapeutic milieu in the workplace that promotes positive patient outcomes and inter-professional well-being is the responsibility of all stakeholders; hence, nursing staff need to work together in achieving success with the proposed guidelines. It is recommended that the proposed guidelines are implemented at community psychiatric facilities within the Province of KZN. The research findings will serve as valuable information for policy makers and primary health care practitioners to work together to ensure that services are effectively integrated, thus encouraging holistic PCC.

10.3.1 Operational managers

The implementation of the proposed guidelines will be navigated by the operational managers. It is recommended that the operational managers ensure that they are familiar with the guidelines and communicate its contents to professional nurses who are in direct contact with MHCUs. Working together as a unit will further promote the components of the proposed guidelines. The operational managers are specialists in their field and are encouraged to effectively disseminate the contents of the guidelines and lead professional nurses in its implementation. Open communication between professional nurses and the operational managers as well as MHCUs will promote the success of the proposed guidelines.

10.3.2 Professional nurses

Professional nurses formed the majority of the participants in the current study and therefore play a pivotal part in the implementation of the proposed guidelines. The findings of the study were used in the development of the guidelines and consequently addressed the concerns and barriers that professional nurses were faced with in ensuring PCC. It is recommended that professional nurses also familiarise themselves with the guidelines as they will

be responsible for the direct implementation as well as ensuring that the MHCUs are actively participating in their care. Building therapeutic nurse patient relationships grounded by effective communication skills will assist professional nurses in achieving PCC.

10.3.3 Mental health care users

Guided by the operational managers, the professional nurses who are in direct contact with MHCUs daily play a key role in ensuring the MHCUs participation. Information regarding the Patients' Rights Charter, PCC and the integration of services should be visibly displayed for MHCUs to access. Information should be available in the commonly spoken languages to promote understanding and compliance. Actively involve patients in their care and allow them to have a voice by participating in patient surveys to improve the care received. The findings of the study showed that MHCUs often became agitated and restless due to the long waiting times. It is important that operational managers and professional nurses are consistent in ensuring that MHCUs are involved in their care as the guidelines suggests.

10.3.4 Recommendations in nursing education

With the phasing out of the legacy nursing qualifications, a new nursing qualification has yet to be developed for basic psychiatry training in the Province of KZN. It is suggested that the proposed guidelines be incorporated into the new nursing qualifications to enhance PCC, especially since nursing is now moving towards a more PHC approach.

10.4 RECOMMENDATIONS FOR FUTURE RESEARCH

Future research is recommended in the following areas:

- The study included only the operational managers and professional nurses in direct contact daily with MHCUs. It is recommended that future research includes all categories of nursing staff working at community psychiatric clinics.

- Psychiatric clinics within the uMgungundlovu district were included in the study; it is recommended that the study is extended to other districts within the Province of KZN.
- The research findings revealed that there were many gaps with the implementation of the policy on the integration of services. It would be interesting to focus on the challenges faced with the downward delegation of implementing changes at ground level.
- The issue of staff shortages runs like a fine thread throughout nursing on a whole. In the current study, staff shortages impacted greatly on the integration of services as well as the ability of nurses to ensure PCC. The implementation of the new nursing qualifications has commenced. Future research on how the implementation of the new nursing qualifications will address the ongoing problem of staff shortages is recommended.

10.5 CONTRIBUTION OF THE FINDINGS TO THE BODY OF KNOWLEDGE

To the researcher's knowledge, this was the first study regarding PCC to be conducted in community psychiatric clinics in the uMgungundlovu district within the Province of KZN. The literature review as well as the study findings suggests that research in the area of psychiatry and mental health is much needed. The findings revealed that many challenges were faced with the implementation of the policy on the integration of mental health into the PHC stream. It further validated that areas of concern were not addressed prior to the implementation of this policy and PCC was not given the importance that it warranted, despite suggesting that the integration of services was patient centred. The study contributes relevant information towards the body of knowledge in the Province of KZN as well as to the existing research done globally. The developed guidelines are intended for policy makers and nursing staff to assist them in ensuring that a balance is maintained when implementing change and sustaining quality patient care. The guidelines are therefore intended to enhance PCC for MHCUs in community psychiatric clinics.

10.6 LIMITATIONS OF THE STUDY

Limitations are barriers or constraints that weaken or decrease the credibility of the study results. These could be the research design, sample of the study or research methods (Botma *et al.* 2010: 107; Burns and Grove 2011: 48). According to de Vos *et al.* (2011: 288), limitations of the study are to be explicit so that precautionary measures may be applied to reduce any possible negative impact that the study could have. In this regard, Grove, Burns and Gray (2013: 598) state that limitations can be identified before conducting a research study and in this current study, the researcher used a limited sample size and provided a detailed description of the methodology of the study. The following limitations were identified in the study:

- The sample included only the operational managers and the professional nurses in direct contact with MHCUs daily, perhaps if all nursing staff were included, the findings may vary.
- The sample also did not include the MHCUs, their views on PCC and the integration of mental health into PHC could have deepened the findings of the study.
- The sample size was relatively small; a larger sample size may yield results that could be generalised to other clinics in the different Provinces.

10.7 FINAL CONCLUDING REMARKS

Chapter 10 included the conclusion, recommendations and limitations of the study. A comprehensive literature review confirmed that there was no study conducted in the uMgungundlovu district within the Province of KZN regarding professional nurses and PCC in community psychiatric clinics. This justified the development of the proposed guidelines in order to enhance PCC for MHCUs in the community psychiatric setting. Furthermore, the literature review also highlighted challenges faced with the integration of mental health into PHC and it was therefore a part of the main aim and objectives of the current study. Despite the limitations of the current study mentioned above, the overall aim and objectives of the study were successfully achieved.

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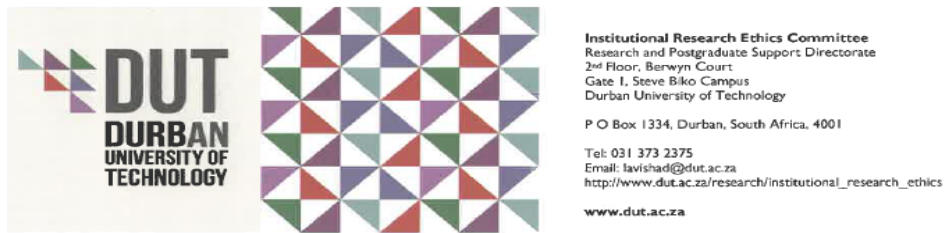
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APPENDICES

Appendix 1: University Ethics clearance



28 August 2019

Mrs L Maharaj
14 Patricia Road
Chase Valley
Pietermaritzburg
3201

Dear Mrs Maharaj

Guidelines to enhance patient centred care for mental health care users in community psychiatric clinics in uMgungundlovu District, KwaZulu-Natal
Ethical Clearance number IREC 089/19

The Institutional Research Ethics Committee acknowledges receipt of your notification regarding the piloting of your data collection tool.

Kindly ensure that participants used for the pilot study are not part of the main study.

In addition, the IREC acknowledges receipt of your gatekeeper permission letter.

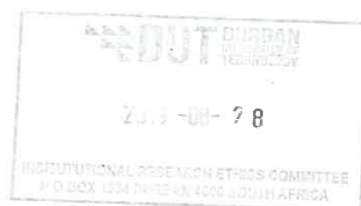
Please note that FULL APPROVAL is granted to your research proposal. You may proceed with data collection.

Any adverse events [serious or minor] which occur in connection with this study and/or which may alter its ethical consideration must be reported to the IREC according to the IREC SOP's.

Please note that any deviations from the approved proposal require the approval of the IREC as outlined in the IREC SOP's.

Yours Sincerely,

Professor J K Adam
Chairperson: IREC



Appendix 2a: Letter of request for permission to the District Manager

14 Patricia Road
Chase Valley
Pietermaritzburg
3201
[Date]

The District Manager
UMgungundlovu Health District
Pietermaritzburg
3201

Request for Permission to Conduct Research

Dear Madam

My name is Loshni Maharaj, a PhD: Health Sciences student at the Durban University of Technology. The research I wish to conduct for my Doctoral thesis involves: *“Guidelines to enhance patient-centred care for mental health care users in community psychiatric clinics in UMgungundlovu District, KwaZulu-Natal.”*

I am hereby seeking your consent to conduct the study at the following psychiatric clinics: Three community health centres (CHCs) namely Bruntville CHC, East Boom CHC and Imbalenhle CHC and three Provincial clinics (Eastwood Clinic, Scottsville Clinic and Woodlands Clinic).

I have provided you with a copy of my proposal which includes copies of the data collection tools, consent form and information letter to be used in the research process, as well as a copy of the approval letter which I received from the Institutional Research Ethics Committee (IREC).

If you require any further information, please do not hesitate to contact me or my supervisor Prof Sibiya on 031-373 2704 Email nokuthulas@dut.ac.za

Thank you for your time and consideration in this matter.

Yours sincerely,

Loshni Maharaj (Researcher)
Telephone: 083 785 8387
E-mail: loshni.maharaj2@gmail.com

Appendix 2b: Approval letter from the District Manager



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

UMGUNGUNDLOVU DISTRICT OFFICE

DISTRICT MANAGERS OFFICE

Enquiries: Mrs. S.W Mbambo
31 JULY 2019

TO: LOSHNI MAHARAJ
HEALTH SCIENCES
UNIVERSITY OF TECHNOLOGY

Dear Ms Maharaj

RE: GUIDELINES TO ENHANCE PATIENT CENTRED CARE FOR MENTAL HEALTH CARE USERS IN COMMUNITY PSYCHIATRIC CLINICS IN UMGUNGUNDLOVU DISTRICT, KWAZULU-NATAL."

I have pleasure in informing you that permission has been granted to you by UMgungundlovu Health District to conduct research on "*Guidelines to enhance patient centred care for mental health care users in community psychiatric clinics in UMgungundlovu District, KwaZulu-Natal.*"

PLEASE NOTE THE FOLLOWING

1. Please ensure that you adhere to all policies, procedures, protocols and guidelines of the Department of Health with regards to this research.
2. This research will only commence once this office has received the full ethics approval has been received and the confirmation from the Provincial Health Research Committee in the KZN Department.
3. Please ensure that this office is informed before you commence your research.
4. The District Office will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the District Office.

Thank you,

MRS S. W MBAMBO
ACTING DISTRICT DIRECTOR
UMGUNGUNDLOVU HEALTH DISTRICT

UMnyango Wezempilo. Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

**Appendix 3a: Letter of request for permission to the to the KZN
Department of Health**

14 Patricia Road
Chase Valley
Pietermaritzburg
3201
[Date]

The Health Research and Knowledge Management Component
KwaZulu-Natal Department of Health
Private Bag X9051
Pietermaritzburg
3201

Request for Permission to Conduct Research

Dear Dr Lutge

My name is Loshni Maharaj, a PhD: Health Sciences student at the Durban University of Technology. The research I wish to conduct for my Doctoral thesis involves: *“Guidelines to enhance patient-centred care for mental health care users in community psychiatric clinics in UMgungundlovu District, KwaZulu-Natal.”*

I am hereby seeking your consent to conduct the study at the following psychiatric clinics: Three community health centres (CHCs) namely Bruntville CHC, East Boom CHC and Imbalenhle CHC and three Provincial clinics (Eastwood Clinic, Scottsville Clinic and Woodlands Clinic).

I have provided you with a copy of my proposal which includes copies of the data collection tools, consent form and information letter to be used in the research process, as well as a copy of the approval letter which I received from the Institutional Research Ethics Committee (IREC).

If you require any further information, please do not hesitate to contact me or my supervisor Prof Sibiyi on 031-373 2704 Email nokuthulas@dut.ac.za

Thank you for your time and consideration in this matter.

Yours sincerely,

Loshni Maharaj (Researcher)
Telephone: 083 785 8387
E-mail: loshni.maharaj2@gmail.com

Appendix 3b: Approval letter from the KZN Department of Health



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Physical Address: 330 Langalibalele Street, Pietermaritzburg
Postal Address: Private Bag X9051
Tel: 033 395 2805/ 3189/ 3123 Fax: 033 394 3782
Email: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:

Health Research & Knowledge
Management

Ref: KZ_201907_045

Dear Ms L Maharaj
(DUT)

Subject: Approval of a Research Proposal:

1. The research proposal titled '**Guidelines to enhance patient centred care for mental health care users in community psychiatric clinics in uMgungundlovu District, KwaZulu-Natal.**' was reviewed by the KwaZulu-Natal Department of Health (KZN-DoH).

The proposal is hereby **approved** for research to be undertaken at Eastwood, East Boom, Woodlands, Scottsville, Bruntville and Imbalenhle clinics.

2. You are requested to take note of the following:
 - a. *Kindly liaise with the facility manager BEFORE your research begins in order to ensure that conditions in the facility are conducive to the conduct of your research. These include, but are not limited to, an assurance that the numbers of patients attending the facility are sufficient to support your sample size requirements, and that the space and physical infrastructure of the facility can accommodate the research team and any additional equipment required for the research.*
 - b. *Please ensure that you provide your letter of ethics re-certification to this unit, when the current approval expires.*
 - c. *Provide an interim progress report and final report (electronic and hard copies) when your research is complete.*
3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Ms G Khumalo on 033-395 3189.

Yours Sincerely

Dr E Lutge

Chairperson, Health Research Committee

Date: 08/07/19

Appendix 4a: Letter of request for permission to the to Clinic Manager

14 Patricia Road
Chase Valley
Pietermaritzburg
3201
[Date]

Mrs N. Mkhabela
KZN Department of Health
Pietermaritzburg
3201

Request for Permission to Conduct Research

Dear Madam

My name is Loshni Maharaj, a PhD: Health Sciences student at the Durban University of Technology. The research I wish to conduct for my Doctoral thesis involves: *“Guidelines to enhance patient-centred care for mental health care users in community psychiatric clinics in UMgungundlovu District, KwaZulu-Natal.”*

I am hereby seeking your consent to conduct the study at the following clinics: Eastwood, Woodlands and Scottsville. I have attached the following letters of approval for your perusal: (1) Institutional Research Ethics Committee (IREC) (2) uMgungundlovu District Manager (3) Department of Health Research Committee.

I have provided you with a copy of my proposal which includes copies of the data collection tools, consent form and information letter to be used in the research process.

If you require any further information, please do not hesitate to contact me or my supervisor Prof Sibiya on 031-373 2704 Email nokuthulas@dut.ac.za

Thank you for your time and consideration in this matter.

Yours sincerely,

Loshni Maharaj (Researcher)
Telephone: 083 785 8387
E-mail:

loshni.maharaj2@gmail.com

Appendix 4b: Approval letter from the Clinic Manager

Maharaj Loshni <Loshni.Maharaj@kznhealth.gov.za>

Tue, Oct 8, 2019 at 2:27 PM

To: "loshni.maharaj2@gmail.com" <loshni.maharaj2@gmail.com>

From: Mkhabela Nokukhanya

Sent: 08 October 2019 08:10 AM

To: 'Angel Dlamini' (angeldlamini123@gmail.com); eastwoodclinic@gmail.com; clinicscottsville@gmail.com; shanenaidoo82@yahoo.com; siwabonilem02@gmail.com; woodlandsclinic@gmail.com

Cc: Chetty Sheldon; Ngcobo Sarah; Maharaj Loshni

Subject: FW: Emailing: Permission - District Manager

Good morning

Please expert Mrs. Maharaj who is doing a research that will involve staff members , she has been granted permission from District . Kindly accommodate her and arrange for the suitable dates and times that will not compromise service delivery in your facility .

Regards

Mrs. Mkhabela

Appendix 5a: Letter of information for the survey participants



Dear Participant

Thank you for agreeing to participate in the study.

Title of the Research Study: Guidelines to enhance patient-centred care for mental health care users in community psychiatric clinics in uMgungundlovu District, KwaZulu-Natal.

Principal Investigator/s/researcher: Mrs. Loshni Maharaj, PhD: Health Sciences Candidate.

Co-Investigator/s/supervisor/s: Prof M.N. Sibiyi D Tech: Nursing.

Brief Introduction and Purpose of the Study: Current literature reveals that mental health services have not effectively been integrated into primary health care, which has a negative impact on mental health care users. The aim of this study is to identify the extent to which mental health has been integrated into the general health stream and ultimately develop guidelines to enhance patient-centred care for mental health care users in community psychiatric clinics in uMgungundlovu District, KwaZulu-Natal.

Outline of the Procedures: You are kindly requested to participate in the survey by responding to all the questions. The questionnaire will take you approximately 15-20 minutes to complete. Thereafter a suitable time will be arranged for the collection of completed questionnaires. I will personally distribute and collect the questionnaire. A box will be made available for you to deposit the completed questionnaire.

Risks or Discomforts to the Participant: There is no anticipated risks or discomfort by participating in the study.

Benefits: The results of the study will be analysed to propose guidelines to enhance patient-centred care for mental health care users in the community psychiatric clinics.

Reason/s why the Participant May Be Withdrawn from the Study: You may withdraw from the study at any stage without any repercussions.

Remuneration: Your participation is voluntary and no remuneration will be provided.

Costs of the Study: You will not bear any costs for participating in this study.

Confidentiality: You will not be required to disclose any personal identifying details; instead a code will be used to number questionnaires.

Research-related Injury: There is no anticipated research-related injury by participating in the study.

Persons to Contact in the Event of Any Problems or Queries: Please contact the researcher Mrs L. Maharaj (Tel. no. 083 785 8387), E-mail loshni.maharaj2@gmail.com OR my supervisor, Prof M.N. Sibiya (Tel. no. 031-373 2704) E-mail nokuthulas@dut.co.za or the Institutional Research Ethics Administrator on 031 373 2375. Complaints can be reported to the Director: Research and Postgraduate Support, Prof C. Napier on 031 373 2577 or carinn@dut.ac.za

Appendix 5b: Letter of information for the interview participants



Dear Participant

Thank you for agreeing to participate in the study.

Title of the Research Study: Guidelines to enhance patient-centred care for mental health care users in community psychiatric clinics in uMgungundlovu District, KwaZulu-Natal.

Principal Investigator/s/researcher: Mrs. Loshni Maharaj, PhD: Health Sciences Candidate.

Co-Investigator/s/supervisor/s: Prof M.N. Sibiya, D Tech: Nursing.

Brief Introduction and Purpose of the Study: Current literature reveals that mental health services have not effectively been integrated into primary health care, which has a negative impact on mental health care users. The aim of this study is to identify the extent to which mental health has been integrated into the general health stream and ultimately develop guidelines to enhance patient-centred care for mental health care users in community psychiatric clinics in uMgungundlovu District, KwaZulu-Natal.

Outline of the Procedures: You are invited to participate on a one-on-one interview that will take approximately 20-30 minutes. The interview session will be conducted at a venue, date and time that is convenient for you. I will facilitate the interview discussion. For record purposes, I kindly request to audio-record the interview discussion.

Risks or Discomforts to the Participant: There is no anticipated risks or discomfort by participating in the study.

Benefits: The results of the study will be analysed to propose guidelines to enhance patient-centred care for mental health care users in the community psychiatric clinics.

Reason/s why the Participant May Be Withdrawn from the Study: You may withdraw from the study at any stage without any repercussions.

Remuneration: Your participation is voluntary and no remuneration will be provided.

Costs of the Study: You will not bear any costs for participating in this study.

Confidentiality: You will not be required to disclose any personal identifying details; instead a code will be used to number the interview guide.

Research-related Injury: There is no anticipated research-related injury by participating in the study.

Persons to Contact in the Event of Any Problems or Queries: Please contact the researcher Mrs L. Maharaj (Tel. no. 083 785 8387), E-mail loshni.maharaj2@gmail.com OR my supervisor, Prof M.N. Sibiya (Tel. no. 031-373 2704) E-mail nokuthulas@dut.co.za or the Institutional Research Ethics Administrator on 031 373 2375. Complaints can be reported to the Director: Research and Postgraduate Support, Prof C. Napier on 031 373 2577 or carinn@dut.ac.za

Appendix 6: Consent



Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, Ms Loshni Maharaj about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: 089/19,
- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

- | | | | |
|--|-------------|-------------|------------------|
| _____ | _____ | _____ | _____ |
| • Full Name of Participant / Right Thumbprint | Date | Time | Signature |
-
- I, Loshni Maharaj herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.
- | | | |
|----------------------------------|-------------|------------------|
| _____ | _____ | _____ |
| • Full Name of Researcher | Date | Signature |
-
- | | | |
|---|-------------|------------------|
| _____ | _____ | _____ |
| • Full Name of Witness (If applicable) | Date | Signature |
-
- | | | |
|--|-------------|------------------|
| _____ | _____ | _____ |
| • Full Name of Legal Guardian (If applicable) | Date | Signature |

Appendix 7: Observation checklist

1. Infrastructure

	Unacceptable	Poor	Fair	Good	Excellent
1.1 Physical condition					
1.2 Adequate space					
1.3 Essential equipment					
1.4 Use of communication and information tools					

Comments

2. Adequate staffing

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Comments

3. Adequate medicines and supplies

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

Comments

4. Good administrative processes

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
4.1 Relevant policies adhered to					
4.2 Protocols and guidelines used					
4.3 Accurate record keeping					
4.4 Safekeeping and control of patient documents					

Comments

5. Waiting times longer than 30 minutes

Never	Rarely	Sometimes	Often	Always

Comments

6. Patients directed to appropriate services

Never	Rarely	Sometimes	Often	Always

Comments

7. Batho Pele principles adhered to:

	Never	Rarely	Sometimes	Often	Always
7.1 Consultation					
7.2 Service standards					
7.3 Access					
7.4 Courtesy					
7.5 Information					
7.6 Openness and Transparency					
7.7 Redress					
7.8 Encouraging innovation					
7.9 Customer impact					
7.10 Leadership and strategic direction					

Comments

Appendix 8: Survey questionnaire

Please **DO NOT** write your **Name** on the questionnaire.

Please select **ONE** answer for each question by using 'X'

SECTION A – DEMOGRAPHICS.

1. Please indicate your gender?

Male	
Female	

2. Please indicate your age.

20 – 30 years	
31 – 40 years	
41 – 50 years	
51 – 65 years	

3. Please indicate your ethnic group.

Black African	
Coloured	
Indian	
White	
Other	

4. Where do you work?

Woodlands	
Scottsville	
Eastwood	
Ghandi	
East Boom CHC	
Imbalenhle CHC	
Bruntville CHC	

5. Please indicate how long you have been in nursing practice.

Less than 10	
10 – 20 years	
21 – 30 years	
31 – 40 years	
More than 40 years	

6. Please indicate your job title.

Professional nurse	
Professional psychiatric nurse	
Operational Manager	
Operational Manager with psychiatry	
Advanced Psychiatric nurse	

SECTION B – CONTACT WITH MENTAL HEALTH CARE USERS AND UNDERSTANDING OF PATIENT-CENTRED CARE.

7. Choose the most appropriate response to your contact with mental health care users in the clinics.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
7.1 You are frequently in contact with MHCUs					
7.2 You practice patient-centred care with every MHCU you are in contact with					
7.3 You are confident in nursing psychiatric patients					
7.4 Patient-centred care is beneficial to MHCUs					
7.5 Mental health care has been effectively integrated into PHC					

8. Indicate your agreement of the following statements you believe to be essential in the successful delivery of patient-centred care to mental health care users.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
8.1 Open communication					
8.2 Positive work environment					
8.3 Adequate resources					
8.4 In-service education on PCC					
8.5 Teamwork					
8.6 Support of the MDT					
8.7 Appropriate nurse-patient relationships					
8.8 Adequate staffing					
8.9 Showing respect to MHCUs					
8.10 Taking the patients' culture into consideration					

9. Indicate your agreement of the following statements you believe to be barriers in the successful delivery of patient-centred care to mental health care users.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
9.1 Staff shortages					
9.2 Time constraints					
9.3 Large numbers of patients					
9.4 Impatient patients					
9.5 Lack of resources					
9.6 Uncaring nurses					
9.7 Inexperienced nurses					
9.8 Inadequate knowledge on patient-centred care					
9.9 Lack of support from management					
9.10 Language barriers					

Thank you for your participation

Appendix 9a: Demographic data for the interview participants

SECTION A: DEMOGRAPHIC DATA

Please answer the following questions in the spaces provided by placing X in the most appropriate option.

1.1 Race

Black	
White	
Indian	
Coloured	
Other specify	

1.2 Please indicate your age

20-30 years	
31-40 years	
41-50 years	
51-65 years	

1.3 Gender

Male	
Female	

1.4 Marital status

Single	
Married	
Divorced/ Separated	
Widowed	
Cohabiting	

1.5 Religious practice

Christian	
siSwati	
Muslim	
Nazareth	
Hindu	
Other	

1.7 How long have you worked at this psychiatric clinic?

Less than 5 Years	
5 - <10 Years	
10 - <15 Years	
15 - 20 Years	
More than 20 Years	

Appendix 9b: Interview Guide

SECTION B: RESEARCH QUESTIONS

- What strategies are used to implement patient-centred care for mental health care users?
- To what extent has mental health been integrated into PHC?
- What changes would you propose in order to enhance patient-centred care for mental health care users?

Based on the participants' responses, probing questions will be asked.

Appendix 9c: A sample of the interview transcript

PHC 1 – Participant 1 OM

19 minutes and 43 seconds

Strategies used to implement PCC??

- We have the chronic stream, but within the chronic stream, we have the mental health area, or a room dedicated to mental health patients, with an RN dealing specifically with mental health patients where they collect all their chronic meds, they will be seen in that room for everything
- PCC is implemented in the clinic, not specifically for psychiatric patients, it's across the board. Our implementation is more along the ideal clinic prescripts and chronic management
- We have the 3 streams and mental health falls into the chronic streams, as much as we try to accommodate them a little more separately in the chronic stream, the queues are too long and the mental health patients are impatient.
- We almost have to create a separate stream within the chronic stream
- We have acute, chronic and mother and child

To what extent has mental health been integrated into PHC

- I think it is yes and no, it is integrated into PHC, however because of the large number that we see in this clinic, it needs to be separated, as I am saying we have a separate room.
- Because of the patient's temperament and the way they behave, we have to create a different stream for mental health
- So that they are treated by a specific nurses
- MHCUs do not like change, they want the routine, when we try to implement changes, they are very reluctant
- For eg, national has implemented the screening of all patients in a central place for all clients visiting the clinic
- The MHCUSs are our biggest barrier for getting that going
- They are used to going to a separate clinic on their own, quite fast, they don't see the need for having their blood pressure taken if they just going to collect their meds

- For TB, because they feel that they don't have TB and there is nothing wrong with them
- Challenges faced – medication comes from THH, so the supply is fairly stable, we don't have challenges with supply, our challenge is with a driver, the doctor will write scripts, the driver has to come collect scripts and take them to THH, and the driver will collect the meds the next day. The MHCUSs have to come back to the clinic the following day to collect their meds, especially when there are changes, if there is no change, we would have meds, but those that are new or changed. Sometimes we are lucky enough if the doctor finishes early enough and then we can send the scripts off about 12 and get it back around 2-3. Sometimes patients wait, sometimes not.
- Patients come in, see the clerk and wait to be screened, it's not possible for the psychiatric patients to just go to any PHC sister, as their meds are packed separately.
- File- screening – distributed according to acute or chronic, seen, get
- We have acute, chronic and chronic mental health stream- they are still separated, one designated person, she also sees PHC patients when she is done
- MHCUS are very impatient, they refuse to stand in queues.
- Some become temperamental, cry, fight,
- Stress to the staff, and staff also falter
- We have had complaints from patients regarding the waiting times
- MHCUSs refuse to join the main stream
- Initially there were issues regarding the separation.
- There have been some challenges and the general queue, we have a large number of white patients and patients want to know why they are going to a separate room.
- Mother and child is priority according to the millennium development goals
- I have done a submission to get another area erected for mental health care patients.

What changes would you propose in order to enhance PCC for MHCUSs?

- I don't think we have the capacity to hold the meds at the facility, safety wise and storage space, we would need lockable cupboards to hold those drugs at the facility.
- Some of the patients understand, but others are not happy, There's a mixed reaction
- Majority of out-patients don't have the transport and funds to go to THH to go and fetch their meds, We are dependent on the driver
- Generally that's not a challenge with the doctor finishing late, Once a week every week and once a month one Friday, We have government vehicle for outreach
- All registered nurses are trained in psychiatric nursing at this clinic, no problem with rotation, unless someone is on leave or off-sick.
- Looking at the number of patients, we need to have a fully-fledged clinic for mental health, It will not be in line with the integration of services
- We have the available space, but not the resources and nurses
- Looking at the numbers of patients, it warrants that, Mental health care users should be in the chronic stream

Key of colours used to identify themes and sub-themes

Yellow – Strategies used to implement PCC

Green – The extent to which mental health has been implemented into PHC

Pink – Challenges faced with the integration/MHCUs temperament

Blue – Changes proposed to enhance PCC

Appendix 10: Feedback from experts who evaluated the developed guidelines

16 June 2020

To whom it may concern

RE: Guidelines to enhance patient centered care mental health care users in community psychiatric clinics in uMgungundlovu District, KwaZulu-Natal.

I have read through the proposed Guidelines and agree that they:

- Are clear and actionable
- Target the relevant stakeholders such as the patient and the service provider
- May enhance patient centered care at an operational level
- Empowers mental health care users and encourages them to play an active role in planning their care.
- Plays avital role in quality improvement and quality assurance processes at an operational level.

Many Thanks

Dr V Naidoo



Validity: Were these practice guidelines evidence based? Please tick:

Yes	No
X	

Comments: The recommendations made were based on the research findings and a literature review. However, I wish MHCUs were included as participants in the study

to instil feelings of being valued, promoting their self-worth and a sense of control in their care and treatment.

.....
.....

Reliability: Are the guidelines reliable? Will they produce the same results when applied by the different practitioners? Please tick:

Yes	No
X	

Comment: The guidelines are reliable they may yield similar results if applied by different practitioners.

.....
.....

Clinical applicability: Are the proposed guidelines aimed at specific population? Please tick:

Yes	No
X	

Comment: The proposed guidelines are applicable to the relevant stakeholders mentioned in the study as they are directly involved in PCC. The issue of home visits by psychiatric nurses seems to be unrealistic, since the country is faced with a challenge of the shortage of Professional nurses. I would suggest the integration of community care givers (as it is the case in PHC) into doing home care or follow-up or training of the lower category of nurses i.e. enrolled nurses for that purpose.

.....
.....
.....

Clarity: Are the guidelines unambiguous? Please tick:

Yes	No
X	

Comment: The proposed guidelines are short, clear and to the point. The MHCUs are the most vulnerable group of patients.

Multidisciplinary process: Were the proposed guidelines reviewed by external reviewers in the relevant field of study? Please tick:

Yes	No
X	

Comment: The guidelines were reviewed by external reviewers in the relevant field of study

.....
.....

Clinical flexibility: Are the proposed guidelines clinically flexible? Please tick:

Yes	No
X	

Comment: The development of these guidelines is highly commended. It came at the appropriate time when there might be a rise of such clients as a result of direct result of the Corona virus (Covid 19) pandemic or indirect results due to lock down associated with this pandemic. It would more appreciated if some guidelines addressing issues related to stigma of being a MHCUs and reasons of defiance/ non-compliance to treatment were also developed. For an example, language barrier or use of medical jargon by healthcare providers is associated with non-compliance to treatment.

.....

Yours sincerely

Dr NP Zikalala

Cell number: 0731641299

Good day,

Kindly receive feedback regarding guidelines to enhance patient centered care for mental health users in community psychiatric clinics in uMgungundlovu District, KwaZulu.

1. The content is logical and clear.
2. The information is relevant and applicable to the relevant stakeholders.

Kind regards
Lucelle

Good afternoon

I've been through the guidelines which is perfect for a new Ops Manager entering the PHC setting and dealing with MHCU.

Missing for me would be the link with the mother facility eg. Townhill for expert review as required and for the provision of the scheduled drugs which is not on code for PHC.

Also the clinician and their relationship with the MHCU doctor who's expected to renew scripts and see first time clients, review challenging cases all of which is done within the PHC setting.

Regards
Shane Naidoo
Scottsville clinic
Ops manager

Feedback on proposed guidelines

The content is relevant and appropriate with regards to PCC in community psychiatric clinics. The information given will serve as a guideline for Operational managers to implement in their psychiatric clinics to ensure a therapeutic and conducive environment is maintained for the Mental health care users. The content also reflects on the importance of the involvement of the MDT , professional nurses , MHCU family and the MHCU for the holistic mental wellbeing of MHCU.

Excellent work.

Regards

Sr.A.Thaver
Ghandi psychiatric clinic.

Appendix 11: Letter of consultation with the statistician

Gill Hendry B.Sc. (Hons), M.Sc. (Wits), PhD (UKZN)
Mathematical and Statistical Services

Cell: 083 300 9896
email : hendryfam@telkomsa.net

11 June 2019

Re: Assistance with statistical aspects of the study

Please be advised that I have assisted Loshni Maharaj (Student number 21240217), who is presently studying for a PhD: Health Sciences at DUT, with the development and validation of the questionnaire for her study.

Yours sincerely

Gill Hendry (Dr)

Appendix 12: Letter from the professional editor

DR NELLIE NARANJEE: LECTURER

Doctorate Nursing, MBA, MCur (Health Sciences)
Freelance academic editor: Blackford Institute, UK

28 Protea Road
Kloof
3610

Contact details

Office : 031 3732036
After hours : 031 7643815
Mobile : 0825776126
Email naranjeen@gmail.com
NellieN1@dut.ac.za

EDITING / PROOFREADING CERTIFICATE

Re: **Ms. Loshni Maharaj (21240217)**

Masters/Doctoral thesis: **Guidelines to enhance patient-centred care for mental health care users in community psychiatric clinics in uMgungundlovu District, KwaZulu-Natal**

I confirm that I have edited this thesis for writing style, clarity, language, sentence structure and layout. The document is formatted according to the prescribed guidelines. I returned the document to the author with track changes. The author remains responsible for the correct application of the changes in the text and references.

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I wish Ms Maharaj all the best.

DR NELLIE NARANJEE

19 July 2020

DATE

Appendix 13: Turnitin report

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