AN INVESTIGATION INTO THE ROLES OF REGISTERED NURSES AND PSYCHIATRIC NURSES AT IN-PATIENT PSYCHIATRIC FACILITIES, AND ITS IMPLICATIONS FOR NURSING EDUCATION IN KWAZULU-NATAL

BY

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DECLARATION

I, Perrene Dale Joubert declare that the content within this dissertation is my own work. All sources that I have used or quoted have been acknowledged in the text by means of complete references. This study has not been previously 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 of signature

APPROVED FOR FINAL SUBMISSION

……. ……

Signature of Professor R. Bhagwan Date of signature

DEDICATION

"Trust in the Lord with all thine heart; and lean not unto thine own understanding. In all thy ways acknowledge him, and he shall direct thy paths". Proverbs3:5, 6.(KGV)

I am thankful and eternally grateful to God, my Heavenly Father for guiding, sustaining and strengthening me throughout this study.

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ABSTRACT

INTRODUCTION

Mental health nurses face challenging positions in practice. They are required to support and care for people hospitalised for treatment of mental illnesses on their recovery journeys but are also expected to manage ward administrative tasks, admit patients, attend meetings, dispense medication and communicate with patients (Gunasekara, Pentland, Rodgers and Patterson 2014: 101; Fourie, Mc Donald, Connor and Bartlett 2005: 135). It has been suggested that mental health nurses spend more time managing the ward environment and staff matters resulting in little time to develop and maintain therapeutic patient relationships (Fourie et al. 2005: 135).

PROBLEM STATEMENT

Research conducted in other countries identified the roles of the psychiatric nurse and mental health care nurses as attending to patients' basic needs, assistance with self-care activities, monitoring and administering medication, ensuring safe environments in the health care setting and health education (Rungapadiachy, Madill and Gough 2004; Bowers 2005; Seed, Torkelson and Alnatour 2010). Although there is evidence of studies in psychiatric and mental health nursing locally, little is known about the roles of registered nurses and psychiatric nurses at in-patient facilities.

OBJECTIVES

- To explore which mental health problems are most commonly seen amongst psychiatric patients at these facilities.
- To investigate the challenges faced by psychiatric nurses when caring for psychiatric patients.
- To investigate what specialized knowledge and skills are required when nursing such patients.

- To investigate whether their education and training prepared them adequately to deal with psychiatric patients and suggest guidelines to strengthen nursing education.

METHODOLOGY

The study utilized a quantitative non-experimental descriptive design to survey registered nurses and psychiatric nurses at in-patient psychiatric facilities in KwaZulu-Natal. A census was utilized in this study as the entire population was sampled. Data were collected using survey questionnaires. Phase two of the study, qualitative content analysis of Psychiatric nursing curricula strengthened the survey findings.

FINDINGS

Findings of this study showed that 98.4% of respondents believe psychiatric nursing care is an important aspect of holistic nursing practice. Respondents agree that challenges are commonly encountered in psychiatric nursing practice and that they are prepared to deal with these patients. However the aspects most frequently identified as needing greater attention in the Psychiatric nursing curricula were The Mental Health Care Act no 17 of 2002 and practical management of aggression, violence and de-escalation.

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ACRONYMS AND ABBREVIATIONS

AIDS: Acquired Immune Deficiency Syndrome

DSM-IV-TR: Diagnostic and statistical manual, fourth edition

HIV: Human Immunodeficiency Virus

KZNCN: Kwa-Zulu Natal College of Nursing

MHCP: Mental health care practitioner

MHCU: Mental health care user

SANC: South African Nursing Council

WHO: World Health Organisation

CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION

A Nurse's Prayer

Give to my heart, Oh Lord....

Compassion and understanding.

Give to my hands skill and tenderness.

Give to my ears the ability to listen.

Give to my lips words of comfort.

Give to me, Lord....

Strength for this selfless service.

And enable me to give hope

To those I am called to serve.

Amen.

www.google.co.za/search

Mental health nurses face challenging positions in practice. They are required to support and care for people hospitalised for treatment of mental illnesses on their recovery journeys, but are also expected to manage ward administrative tasks, admit patients, attend meetings, dispense medication and communicate with patients (Gunasekara, Pentland, Rodgers and Patterson 2014: 101; Fourie, Mc Donald, Connor and Bartlett 2005: 135). It has been suggested that mental health nurses spent more time managing the ward environment and staff matters, resulting in little time to develop and maintain therapeutic patient relationships (Fourie *et al*. 2005: 135).

The primary role of nursing in relation to health resulted in the development of the idea of holism being the key philosophy for nursing. Holistic nursing care can be

traced to Florence Nightingale, who acknowledged the psychological and spiritual aspects of patients, whilst attending to their physical needs (Happell and Platania-Phung 2005: 41). In order to render holistic care, psychiatric nurses must be able to deal with the psychological dimensions, as well as physical care (Mc Cabe 2002: 52; Happell and Platania-Phung 2005: 41). Barker (2003: 489) stated that holism in psychiatric-mental health nursing referred to the "importance of the whole and the interdependent parts" in nursing care. Mc Cabe (2002: 52) added that mental health care included a progression from disease towards mental health and illness prevention.

The World Health Organization (WHO) defined health as complete physical, mental, social stability and wellbeing and not merely the absence of disease or illness (Alma-Ata 1978: 2; 2001:8). Happell and Platania-Phung (2005: 41) stated that health included the biological, social, psychological and spiritual aspects of a person's life. These attributes can be influenced by genetic, biological, social and environmental factors, which merge to cause mental and brain illness (WHO 2001:8). Mental health is a significant foundation for an individual's attainment of emotional, intellectual, economic, social and educational well-being. WHO (2001: 13) and Funk, Drew and Knapp (2012: 166) further argued that there is a strong link between poverty and mental disorders. These researchers found that mental disorders have diverse and extensive social impacts, viz. homelessness, increased rates of imprisonment, poor educational opportunities and outcomes and lack of employment, giving rise to reduced income.

It has been suggested that 14% of the global burden of disease is attributed to mental disorders (Ngui, Khasakhala, Ndetei and Roberts 2010: 235; Tomlinson, Rudan, Saxena, Swartz, Tsai and Patel 2009: 438). Depression is present in more than 450 million people, mostly from poor and developing countries (Saxena, Sharan, Cumbrera and Saraceno 2006: 179). Mathers and Loncar (2006: 2011) predicted that by 2030 unipolar depressive disorders will be one of the three leading causes of disability.

In fact, researchers have estimated that almost one in five people will experience a mental illness during their lifetime (Uys and Middleton 2010: 43). Mental illness affects people in the prime of their lives, often during adolescence or at the young

adult developmental stage (Uys and Middleton 2010: 43; Lu, Lo, Sung, Hsieh, Yu and Chang 2013: 684). In South Africa Lund, Kleintjes, Kakuma and Flisher (2010: 394) reported that about 17% of children and adolescents in the Western Cape suffer from mental disorders. Mental illness adversely affects the person's brain and at times requires long-term treatment. Most individuals experience ongoing disability and have been a challenge to rehabilitate vocationally (Uys and Middleton 2010: 43).

Mental health is receiving increased attention in South Africa (Lund *et al.* 2010: 394). In South Africa, neuropsychiatric conditions have been ranked third in terms of their contribution to the burden of disease (Bradshaw, Norman and Schneider 2007 cited in Lund *et al*. 2010: 394). Studies found that 16.5% of adult South Africans suffered from common mental disorders, viz. depression, anxiety disorders and substance use disorders (Williams, Herman, Stein, Heeringa, Jackson, Moomal and Kessler 2008: 213). It was established that chronic diseases or non-communicable diseases, viz. diabetes mellitus, hypertension, kidney disease, cervical and prostate cancer and mental illness, accounted for 35% of the disease burden in 2000 in South Africa (Chopra, Lawn, Sanders, Barron, Karim, Bradshaw, Jewkes, Karim, Flisher, Mayosi, Tollman, Churchyard and Coovadia 2009: 1023).

Psychiatric nurses in South Africa function within the frameworks of specific legislation. The cornerstone of South African democracy, in Chapter 2 of the Bill of Rights, Section 27, states that all South Africans have a right to access health care services (Constitution of the Republic of South Africa Act No108 of 1996: 12).

The Nursing Act 33 of 2005 provides for education, training, research, registration and practice of nurses. Chapter 2 of the Regulations relating to the Scope of Practice of Registered nurses entails "the establishment and maintenance, in the execution of the nursing regimen, of an environment in which the physical and mental health of a patient is promoted" (Nursing Act 33 of 2005: 25; Regulation Relating to the Scope of Practice of Persons who are Registered or Enrolled under the Nursing Act, 1978: 2).

In South Africa (2002) it has been recognised that health is concerned with physical, mental and social well-being and that mental health services should be

provided as part of primary, secondary and tertiary health services. The Act allowed for the best possible mental health care, treatment and rehabilitation services rendered to South Africans, equitably and efficiently, as allowed by the available resources (Mental Health Care Act 17 of 2002: 1).

In line with the WHO proposal to integrate mental health services into primary health care, mental health services in South Africa prioritised holistic services rendered to mentally ill individuals on primary, secondary and tertiary levels (WHO 2008: 12). An individual receiving care, treatment and rehabilitation services at a health facility in South Africa is referred to as a mental health care user (MHCU). A mental health care practitioner (MHCP) is a qualified nurse who has been trained in psychiatric nursing care and is competent in providing care, treatment and rehabilitation of mental health care user's (MHCUs) (Mental Health Care Act No 17 of 2002: 5). These definitions of psychiatric nurse, mental health care practitioner, psychiatric patient and mental health care user will guide this study.

The types and categories of mental illness influence the care rendered by psychiatric nurses and MHCPs. A study conducted at an in-patient psychiatric facility in Australia indicated that, of a sample of 122 patients, 42% were frequently diagnosed as schizophrenic. Other conditions included mood disorders (29%), whilst the remaining 29% of patients presented with mental illnesses, viz. delusional disorder, personality disorder, schizoaffective disorder, substance abuse disorder and unspecified depressive disorder. Eleven patients (9%) were diagnosed with more than one mental illness (Wynaden, Mc Gowan, Chapman, Castle, Lau, Headford and Finn 2001: 843).

The literature reflects the impact of verbal abuse on nurses working with psychiatric patients. For example, it was found that in Singapore there were 42 incidents of verbal abuse reported; 66% were initiated by patients diagnosed as schizophrenic. Patients between the ages of 30 and 49 years were responsible for more than 50% of these incidents (Yusuf, Hendricks, Eng, Kandasamy, Kim, Selvarani and Adeline 2006: 31).

Similarly, a survey of nurses at acute and chronic wards in Japan found that 61% (n=141) of nurses were exposed to verbal abuse and violence where

schizophrenia was predominant (Inoue, Tsukano, Muraoka, Kaneko Otr and Okamura 2006: 31).

Nurses working in forensic psychiatric wards in Australia often care for violent and aggressive patients. Of the 316 incidents reported, verbal aggression (62%) was most frequently identified, followed by physical aggression (29%), and patient damage to property was 29% (Daffern, Mayer and Martin 2006: 96).

Similar findings were made in South Africa. A needs assessment of persons (n=60) attending an outpatient clinic in the Limpopo province revealed that 90% of respondents were diagnosed as schizophrenic and were within the age group 15 to 55 years. It was reported that more than 52% (n=31) of respondents were male, whilst 48% (n=29) of respondents were female. Respondents' ages ranged from 21 to 60; however, 43% of respondents were 41 to 60 years (Manamela, Ehlers, van der Merwe and Hattingh 2003: 91).

An added feature in the literature was the problem of recurrent admission. Frequent readmissions of people with chronic schizophrenia at a psychiatric hospital in Ethiopia reduced the bed occupancy space for acute psychiatric patients, negatively impacted services and distracted staff from caring for acute persons. In a qualitative study, Bimerew, Sonn and Kortenbout (2007: 80) found that family members (n=12) agreed that schizophrenic people in their care usually abused substances, which contributed to frequent readmissions.

In line with the frequency of readmission rates of patients, a review of patients' files was conducted between 2004 and 2007 at an acute psychiatric ward in Johannesburg. Data indicated that 436 patients were diagnosed with schizophrenia. Eighty percent (n=348) of these patients were admitted once during this period, whilst 20% (n=88) of patients were admitted on multiple occasions. Thirty three percent (n=146) of respondents were found to abuse substances at least once at the time of admission (Janse Van Rensburg and Olorunju 2010: 204).

Psychiatry remains a significant discipline within medicine. In the article "No health without mental health", Gillis, Robertson, Zabow and Stein (2012: 449) emphasize how psychiatric illness influences behaviours such as patients' adherence to

medication, which in turn has a positive or a negative outcome on the patients' medical progress. Nurses employed in psychiatric services are the largest group of health care professionals and often spend the most amount of time with mentally ill individuals. This places nurses in a vital position to assist clients achieve and maintain an ideal level of mental functioning. Nurses understand the challenges in health care systems and utilise wellness programmes to promote health and prevent illness (Caldwell and Jorm 2000: 603; Wynaden *et al.* 2001: 842; Happell and Platania-Phung 2005: 41; Fourie *et al.* 2005: 135; Lesinskiene, Jegorova and Ranceva 2007: 758; Happell, Palmer and Tennent 2011: 901).

Whilst there is much global literature documented on psychiatric or mental health nursing care at in-patient settings, South African research in this field of nursing is sparse. The nursing studies conducted at in-patient psychiatric facilities have used primarily a qualitative design (Mavundla 2000: 1569; Bimenyimana, Poggenpoel, Myburgh and van Niekerk 2009: 4; Ngako,van Rensburg and Mataboge 2012: 2).This, together with the increasing evidence of global empirical studies regarding challenges in caring for psychiatric in-patients, prompted a need for the current study. The purpose of this study was therefore to investigate the roles of registered and psychiatric nurses at in-patient psychiatric facilities, the primary challenges in caring for these patients and their educational preparedness to deal with this specialized area of nursing practice.

1.2 HISTORICAL BACKGROUND OF PSYCHIATRIC-MENTAL HEALTH NURSING

Historically, mental illness was believed to be caused by supernatural or magical powers which entered the person's body. A few methods that were utilized to cure or treat the illness included exorcism, baths and beatings to purge the body of the unwanted force. In Africa, the traditional treatment of mentally ill persons is still based upon this model and consists of treatments such as herbal remedies, rituals and fortune-telling (Townsend 2009: 12; Uys and Middleton 2010: 4).

The history of mental health nursing can be traced to the eighteenth and nineteenth centuries, when the nurse was named a keeper, attendant, mental

nurse, psychiatric nurse, nurse therapist and mental health nurse (Rungapadiachy, Madill and Gough 2004: 714). During this period, mentally ill persons, who were housed in large institutions with prostitutes, indigent individuals and unmarried mothers, were separated and cared for in 'asylums' or 'sanctuaries' (Uys and Middleton 2010: 4). In South Africa, wealthy families of those who were mentally ill cared for these individuals at home, whilst mentally ill persons of poorer backgrounds were cared for by families in the community, who received financial support from the church (Uys and Middleton 2010: 4).

The nineteenth century signified a worldwide increase in the number of mental institutions. In 1846 the first psychiatric hospital in South Africa was established on Robben Island, as an institution for lepers, chronically ill and mentally ill patients (Uys and Middleton 2010: 5; Gillis *et al.* 2012: 449).

Internationally, the increased numbers of psychiatric institutions during the twentieth century resulted in a change from small facilities, where patients received moral forms of treatment. The larger facilities resulted in patient overpopulation and inadequate staffing, which led to staff using non-therapeutic measures, viz. shackles, mechanical restraints and isolation cells. These issues were addressed by the "Mental Health Society", which emphasised the need for creating a therapeutic environment by avoiding the use of restraints, isolation and high fences. Psychopharmacology, as a chemical restraint measure, advanced further, allowing for the management of difficult patients, and led to the deinstitutionalisation of psychiatric patients and to management in the communities. Hildegard Peplau, who was termed the mother of mental health nursing, developed the model of interpersonal relationships in nursing, thereby influencing the role of the mental health nurse (Uys and Middleton 2010: 6).

Psychiatric services in South African institutions during this period were not adequate. Iris Marwick was appointed as a correspondent to the International Council of Nurses, regarding mental health issues in South Africa. The areas of concern which were reported included patient overpopulation, poor working conditions and staff shortages, longer hours of duty and lower salaries, in comparison to nurses in other sectors of nursing. Mental health nursing in South Africa has progressed to modern therapeutic techniques, day care facilities and

the open-door policy, which was implemented at a Johannesburg psychiatric hospital. Community psychiatric services have been provided by social workers since the 1920s. However, the first psychiatric institution, which was located in Randburg, under the guidance of Dr M.B. Feldman and his team, initiated a community psychiatric outpatient service. This service offered patients emotional support once they were discharged (Uys and Middleton 2010: 8).

The WHO (1978:16), at the Alma-Atta Declaration, and national and international agencies, identified the need to move to primary health care. This initial declaration omitted mental health care. World health policy-makers have since acknowledged the importance of mental health and its link with socio-economic and socio-cultural factors in all societies (Alma-Atta Declaration 1978: 16; Uys, Subedar and Lewis 1995: 348; Uys and Middleton 2010: 11).

In South Africa, the Department of Health (Uys and Middleton 2010: 11) adopted the primary health care approach, in alignment with the Alma-Atta Declaration (WHO) (1978:16). The current trends in mental health nursing influenced the role of the mental health care practitioner. These trends reflect firstly, progressive advancement of primary health care services and, secondly focus on psychosocial rehabilitation. At present, health care policy-makers acknowledge the importance of mental health and its link with economic and cultural factors in societies, thereby reinforcing the value of psychosocial rehabilitation (Uys and Middleton 2010: 11).

The macroeconomic report of the WHO stated that mental illness and poverty were interconnected (Duncan, Swartz and Kathard 2011: 64). It was confirmed that poor housing, overcrowding, unemployment and income uncertainty are related to common mental disorders such as anxiety and depression. Poverty increases participants' vulnerability to mental distress, whilst mental ill-health increased the risk of enduring poverty (Duncan, Swartz and Kathard 2011: 64). Exposure to continuous poverty has been shown to increase adolescents' risk for depression, substance abuse and criminal activity (Dashiff, Di Micco, Myers and Sheppard 2009: 24). Several writers stated that social and psychosocial problems, viz. interpersonal violence and poverty, contribute towards vulnerable individuals developing a mental illness (Petersen 1999: 907; Mavundla 2000: 1570).

The significance of mental health and mental illness has its foundations in the cultural beliefs of the society. Behaviours which are considered acceptable in one society or cultural group may be viewed as inappropriate in another. The definition of mental illness “depends on a society’s norms or rules of behaviour” (Bilgin and Buzlu 2006: 77; Townsend 2009: 14). Some communities placed emphasis on the spiritual link to illness. Wilson (2010: 719) said that African Americans believed that spiritual factors were important influences in the causes and treatment of mental illness. The importance of mental illness and spirituality was emphasized during patient interviews in this study (n=16). It was found that patients “prayed a lot, referred to their belief in God and the importance of prayer in their daily life” (Wilson 2010: 719).

In South Africa, a survey conducted with schizophrenic patients (n=60) in the Limpopo province found that all the participants were church members. More than 35% (n=22) of the respondents indicated that they believed the church leader could perform miracles to cure mental illness (Manamela *et al.* 2003: 93).

1.3 PROBLEM STATEMENT

The role of the mental health nurse has been described as demanding, challenging and has resulted in nurses working in complex environments, globally and locally. Nurses were found to spend more time on administrative and clerical duties than rendering care to patients. Factors such as insufficient staffing and increased work load were identified as stressors in acute mental health care settings (Ryrie, Agunbiade, Brannock and Maris-Shaw 1998: 849; Mavundla 2000: 1570; Cleary 2004:54; Jenkins and Elliott 2004: 622; Huang, Ma, Shih and Li 2008: 3031; Ngako, van Rensburg and Mataboge 2012: 1).

Research conducted in other countries identified the roles of the psychiatric nurse and mental health care nurses as attending to patients’ basic needs, assistance with self-care activities, monitoring and administering medication, ensuring safe environments in the health care setting and health education (Rungapadiachy, Madill and Gough 2004: 719; Bowers 2005: 231; Seed, Torkelson and Alnatour 2010: 160).

According to Uys and Middleton (2010: 18), psychiatric nurses locally seemed to find it difficult to clarify the roles of the psychiatric nurse. Psychiatric nursing activities include domestic and clerical supervisory duties, serving patients' meals, administering patients' medication, admissions and the restraint of violent patients.

Mental health in South Africa is receiving recognition as being an important public health and developmental issue (Lund *et al.* 2010: 393). This is evident in the Mental Health Care Act No 17 (2002: 1), which recognised that mental health care should be undertaken as part of primary, secondary and tertiary health care services. Despite there being minimal research in the field, a few qualitative inquiries were found in the literature. Lethoba, Netswera and Rankhumise (2006: 10) identified a gap which related to the effect that integration of knowledge and skill had on comprehensive nursing care and its impact on nurses' attitudes when caring for mentally ill patients. The most salient study was by Mavundla (2000:1574), who found that nurses have indicated that most psychiatric patients are very aggressive and violent and tend to threaten and abuse the nurses and other patients in the ward. He therefore recommended that professional nurses needed more knowledge and skills to help this group of patients.

In another study by Ngako, van Rensburg and Mataboge (2012: 5), the environment at an acute in-patient public health facility in Gauteng was found to be characterised by MHCUs' violence, disrespectful behaviour and sexual intimidation (Ngako, van Rensburg and Mataboge 2012: 5). Three themes emerged from focus group discussions with male (n=8) and female (n=13) participants. Firstly, nurses felt unsafe in these environments. Negative emotions and attitudes compromised nursing care which was rendered. Lastly, participants believed that a caring and supportive workplace environment would promote quality nursing care in these wards (Ngako, van Rensburg and Mataboge 2012: 5).

Similar findings were reported in a study at an in-patient forensic facility in Gauteng. Interviews with males (n=2) and females (n=7) revealed that this group of nurses worked in stressful settings. These nurses were exposed to hostile behaviour from patients, which hindered the therapeutic nurse-patient relationship. Participants said that they felt disempowered and that they lacked support from management (Tema, Poggenpoel and Myburgh 2011: 917).

Although there is evidence of studies related to the challenges faced in psychiatric and mental health nursing, locally little is known about the roles of registered nurses and psychiatric nurses at in-patient facilities. The present researcher's experience of working at a psychiatric facility supported the need to identify the roles of psychiatric nurses working at these facilities. Findings of an investigation into the lived realities of psychiatric nurses (n=10) at a Gauteng psychiatric institution lent further impetus to the study. Interviews revealed that nurses "are expected to do everything, like when the psychologists come here they all depend on you for assistance", "a doctor will expect you to do everything", "usually the doctors will come and prescribe something, but they don't help. You are just left alone there, you don't get help" (Bimenyimana *et al.* 2009: 7).

There is thus a need to investigate what specialized knowledge and skills are required and to explore whether or not these nurses are adequately prepared when caring for these patients. Hlahane, Greeff and du Plessis (2006: 82) explored professional nurses perceptions of the skills needed to render services at primary health clinics within the Potchefstroom Health District. The findings from their interviews with professional nurses' (n=22) indicated that participants lacked confidence, they perceived that they lacked skills in medication management and they felt that they could not conduct proper patient assessments (Hlahane, Greeff and du Plessis 2006: 88).

This together with the paucity of local research, prompted the need for this study. The primary aim was to investigate the roles of registered nurses and psychiatric nurses, the common problems encountered in nursing care, the most common mental health problems seen amongst in-patients and the preparedness of registered nurses and psychiatric nurses to work in this specialized field. Hence the research question summarises the problem of this study viz. what are the roles of registered nurses and psychiatric nurses at in-patient psychiatric facilities?

1.4 SIGNIFICANCE OF THE STUDY

Research in the area of psychiatric nursing in South Africa is of value, given the paucity of local literature related to this topic. Psychiatric nursing roles have

received growing acknowledgement internationally; however the roles of psychiatric nurses at local in-patient mental health care facilities have not been fully investigated. In view of the background and the problem statement, this study investigated the roles of registered nurses and psychiatric nurses at in-patient facilities, the primary challenges in caring for these patients and their educational preparedness to care for these patients. Guidelines and recommendations for policy developers with regard to educational preparation of this group of nurses and input for curriculum developers of nursing programmes (R880 and R425) (SANC 1975 and 1985) will be provided.

1.5 AIM OF THE STUDY

The aim of the study is to investigate the roles of registered nurses and psychiatric nurses at in-patient psychiatric facilities, the primary challenges in caring for these patients and their educational preparedness to deal with this specialized area of nursing practice.

1.6 OBJECTIVES OF THE STUDY

- To explore which mental health problems are most commonly seen amongst psychiatric patients at these facilities.
- To investigate the challenges faced by psychiatric nurses when caring for psychiatric patients.
- To investigate what specialized knowledge and skills are required when nursing such patients.
- To investigate whether their education and training prepared them adequately to deal with psychiatric patients and suggest guidelines to strengthen nursing education.

1.7 CONCEPTUAL FRAMEWORK

A framework helps to guide and organise the study and provides the context in which a problem is investigated and data are collected and analysed. A conceptual framework is one that has been developed by a researcher through identifying and defining concepts and proposing relationships between the concepts. Through the development of a framework, which reflects organised ideas, the researcher shows that the proposed study is a logical extension of current knowledge (Brink 2002: 29). According to Polit and Beck (2012: 128) a study that originates from a specific conceptual model has been defined as a conceptual framework.

The Tidal Model of mental health recovery and reclamation was used as a guide for this study. This model uses the tidal ebb and flow of water to metaphorically describe the unpredictable and changing nature of life experiences (Barker 2001b: 217). Emphasis is placed on the psychiatric crisis experienced within the person's "whole lived experience, or life world" (Mc Cann 1993 cited in Barker and Buchanan-Barker 2010: 173).

In this model, life is seen as a journey undertaken on an ocean of experience. All human development, including events of illness and health, involves discoveries on the journey across the ocean of experience. At critical points in the life journey the person encounters storms and crises. The person may need to be guided to safety to recover or rehabilitate from the trauma, following which they continue on life's journey (Barker 2001a: 81).

The model is based upon the development of a person-centred care approach in psychiatric nursing. It focuses on helping people who have experienced a psychiatric crisis, rather than on the behaviour, and on supporting the person during recovery. The care rendered should not be restricted to a hospital; instead it "flows across artificial boundaries", as a person's needs change (Barker 2001b: 217; Merritt and Procter 2010: 159).

The Tidal Model was originally developed to address the sense of loss of purpose and focus of acute psychiatric nursing care. The Model stemmed from a few studies which explored several views in nursing, viz. nurses' ideas of their role, the "need for psychiatric nursing", as perceived by patients, family and spouses or

partners, members of the multidisciplinary team and nurses and the “power-relationship” between the nurse and the patient (Barker 2001b: 215). The Tidal Model focuses on assisting the psychiatric nurse in understanding the person and their relationship with illness and health. Barker (2001b: 218) stated that the person’s story emerged through three distinct and interrelated dimensions, viz. world, self and others in caring.

The world-dimension focused on a person’s need to be understood and to have concerns and challenges validated by psychiatric nurses and others. In line with the person-centred approach, a Tidal Holistic Assessment document allowed the person to document in *their own voice,* the perceptions of events surrounding the illness and what needs to be done to help them during illness and recovery (Barker 2001b: 218). Although it was a survey, this study will explore the common mental health problems, the behavioural patterns seen amongst psychiatric patients and the challenges psychiatric nurses face when caring for patients.

Self-dimension highlights the need for emotional and physical security. This dimension of the Tidal Model is given priority, since emotional and physical security hinge upon the nurse and patient forming an effective therapeutic relationship (Barker 2001b: 218). The nurse helps the patient to develop a Personal Security Plan, which reflects the support needed to assist the nurse and patient working through issues identified in the world dimension (Barker 2001b: 218). This portion of the Tidal Model suggests the empowerment and development of psychiatric nurses in nursing practice (Brookes, Murata and Tansey 2008: 26). Application of the self-dimension aspect in this study relates to psychiatric nurses indicating their levels of comfort, confidence and preparedness to care for these patients. Respondents will be requested to indicate what specific knowledge, skills and training psychiatric nurses require when caring for these patients. Section 4 of the questionnaire investigated psychiatric nurses’ preparedness to care for psychiatric patients.

When formulating a patient care plan, the dimension related to “others” refers to the nurse and patient recognising that the latter requires support from family and community members and also medical, social and financial support (Barker 2001a: 83). Application of this dimension to this study refers to the support from “others”,

viz. nursing management and nursing education through development, empowerment and guidance of the respondents. In this study, the respondents' training needs, the types of training methods and suggestions for input into the training programme will receive attention. These findings and recommendations will be made available to nursing education planners and nursing managers.

1.8 OPERATIONAL DEFINITIONS

- **Mental health care practitioner**

A psychiatrist, a medical practitioner, nurse, occupational therapist, psychologist or social worker who is trained and competent to provide appropriate mental health care, treatment and rehabilitation services (Mental Health Care Act No 17 of 2002:5).

- **Psychiatric nurse**

A psychiatric nurse is a registered psychiatric nurse who is registered with the South African Nursing Council (Bimenyimana *et al*. 2009: 6).

- **Mental health care user**

"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 the user" (Mental Health Care Act No 17 of 2002:5).

- **Health establishment**

This means "institutions, facilities, buildings or places where persons receive care, treatment and rehabilitative assistance, diagnostic or therapeutic interventions, or any other health services, and includes facilities such as community health and rehabilitation centres, clinics, hospitals and psychiatric hospitals" (Mental Health Care Act No 17 of 2002: 5).

1.9 PRESENTATION OF THE CHAPTERS

Chapter 1 of the study introduced psychiatric-mental health nursing and a historical overview of this field. The problem statement, significance of the study, research aim and objectives were outlined. Chapter 2 is an in-depth review of literature related to psychiatric-mental health nursing. In Chapter 3 the two sequential phases guiding the methodology, viz. the quantitative research paradigm, followed by qualitative documentary content analysis, are discussed. Chapter 4 emphasizes the major findings of the study and in Chapter 5 an interpretation of the data, guidelines and recommendations for psychiatric nursing education, practice and further research is made.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

A literature review is a systematic presentation of existing, previously researched areas relevant to the topic (Mouton 2001: 86; Burns and Grove 2009: 39; Polit and Beck 2012: 58). The review of literature enabled the identification of previously theorized, conceptualized thoughts and the instruments utilized to obtain empirical findings. The purpose of the literature review is to summarize, analyse, synthesize and evaluate the previous literature based upon the focus of the current study (Mouton 2001: 86; Burns and Grove 2009: 39; Polit and Beck 2012: 58).

Much of the literature was concentrated abroad, since research in psychiatric nursing is still growing in this area, locally. Literature and information was obtained from books, electronic data bases, namely, Wiley, Ebscohost, PubMed, ProQuest, Summon Serial Solutions and Science Direct. The review begins with definitions of a psychiatric nurse, psychiatric nursing and mental health nursing. Literature related to patient care in psychiatric nursing, the roles of psychiatric nurses, patients' behavioural and clinical problems, the challenges encountered in nursing and their educational preparedness to care for psychiatric in-patients is then reviewed.

2.2 DEFINITIONS OF A PSYCHIATRIC NURSE AND PSYCHIATRIC NURSING

A psychiatric-mental health registered nurse is a nurse who has competence in caring for patients with mental health issues, problems and psychiatric disorders. A psychiatric nurse obtains specialised skills, abilities and knowledge through education, training and experience (American Nurses' Association 2007 cited in Townsend 2009: 749).

Mental health nursing or psychiatric nursing in Ireland has been described as a specialized branch of nursing, with a strong emphasis on the importance of the therapeutic interpersonal nurse patient relationship (Cameron, Kapur and Campbell 2005: 64).

Psychiatric and mental health nursing are interrelated (Barker 2001b: 217; 2003: 8). The former can be seen as a type of “lifesaving psychiatric rescue” of the person in “acute” distress. This form of nursing care requires specialised skill, which may include crisis intervention either in an acute in-patient setting or in a community environment (Barker 2001b: 217; Barker 2003: 8). However, once the crisis has passed and the person appears to have calmed down, the emphasis changes to rehabilitation and returning the person to a normal and meaningful life in the community. This is termed mental health nursing. The nurse and the person work collaboratively in understanding the problems which the person may encounter and plan solutions to these problems (Barker 2003: 9).

A registered psychiatric nurse in the South African context is a nurse who has met the requirements of the South African Nursing Council (SANC) Regulation (R880) Diploma in Psychiatric Nursing, which is a 12-month programme (SANC 1975). A registered psychiatric nurse is a nurse who has met the requirements of the SANC Regulation (R425) Diploma (General, Psychiatric and Community) and Midwife. This was a six month module incorporated in the R425 programme, which extends over a four year period (SANC 1985). Psychiatric nursing in South Africa has been described as a speciality within the nursing profession, which focuses on the promotion of mental health, prevention of mental illness, early identification of, and intervention in, emotional disturbances, with follow-up care aimed at minimizing long-term effects of mental illness in clients. Mental illness has been further described as a diagnosis of mental health related conditions, as stipulated by the diagnostic criteria stated in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (Uys and Middleton 2010: 209).

This chapter also reviews studies related to psychiatric nursing and mental health nursing. The literature review will be discussed by using the following headings which are aligned with the study aim and objectives.

- Roles, functions and activities of registered nurses and psychiatric nurses.
- The types of behaviour and clinical problems registered and psychiatric nurses encounter in practice.
- The challenges registered nurses and psychiatric nurses face when caring for these patients.

- The preparedness, competency and development of nurses in this area of speciality.

2.3 HOLISTIC CARE IN PSYCHIATRIC NURSING

Nursing is assisting persons holistically to use their adaptive strengths to attain and maintain optimum bio-psycho-socio-spiritual functioning (George 2002: 473). The nursing profession supports holism as its philosophy of care. This philosophy promotes the physical, psychological and social aspects that are related to nursing care (Happell and Platania-Phung 2005: 41).

It has been found that mentally ill people experience more physical illnesses, the most significant being cardiovascular disease and diabetes mellitus. Health-related factors, which contribute towards mentally ill persons experiencing poorer physical health outcomes, were related to poor nutrition, a lack of physical exercise, smoking, alcohol and drug abuse (Lawrence, Holman and Jablensky 2001 cited in Johnson and Fry 2013: 163).This supports the need to deal with the physical and mental aspects holistically.

In Australia it was found that almost 30% of medical and surgical admissions were characterised by depression and anxiety (Clarke *et al*. 1991 cited in Happell and Platania-Phung 2005: 44). Forty two percent of women diagnosed with breast cancer were also diagnosed with depression and anxiety (Kissane, Clarke, Ikin, Bloch, Smith, Vitetta and McKenzie 1998 cited in Happell and Platania-Phung 2005: 44). Paying attention to patients' mental health needs is therefore not just an issue of caring and promoting wellbeing; mental illness has a significant adverse effect upon the course and outcomes of physical illness. Reducing mental illness rates would result in improved physical health outcomes (Happell and Platania-Phung 2005: 46).

An online survey of the attitudes and practices amongst Australian staff from the professional categories of social work, psychology and welfare departments was conducted (Johnson and Fry 2013: 166). Of the 1500 participants, only 25% (n=373) completed the survey. Ninety five percent of these respondents were in agreement with the statement that "people who experience mental illness have

poorer physical health than the general population" (Johnson and Fry 2013: 166). From a list of 14 areas, respondents were requested to indicate the types of physical, health-related support they provided to clients. Respondents reported that the most common type of physically related support provided was access to physical health services, viz. 87% of respondents assisted mentally ill persons with general practitioner access, 86% of respondents rendered community health services, 81% of respondents offered clients assistance with physical exercises, whilst 75% of respondents focused on the persons nutritional needs (Johnson and Fry 2013: 166).

As with other categories of professionals, nurses are expected to render holistic nursing care, which includes assessment of patients' physical health needs and the promotion of a healthy lifestyle in psychiatric nursing care (Howard and Gamble 2011: 105). An investigation of registered nurses' (n=78) views of physical assessments and caring for mentally ill people in an acute in-patient setting in the United Kingdom was conducted. Seventy five percent (n=27) of participants suggested that it was important to address the physical needs of clients, whilst 86% (n=31) were very confident in weighing and identifying fluctuations in patients' body weight and monitoring vital signs, viz. blood sugar and blood pressure. An audit of patients' notes revealed that 57% of patients' blood pressures were checked on admission. The participants reported receiving insufficient education and training, whilst 75% of the respondents had not received any training and development. However, participants commonly requested training related to care of diabetic patients.

A needs assessment of schizophrenic patients (n=60) receiving treatment in Limpopo province was conducted (Manamela *et al*.2003: 88). Results revealed that all respondents had poor physical health, over 70% of respondents reported that they felt dissatisfied with their level of education and this was related to their psychological and emotional needs. More than 70% of respondents stated that they were satisfied with their participation in family and social events. It was further reported that, despite a lack of psychiatric services, the majority (88%) of respondents reported that they took medication regularly, which influenced the outcome of patient care. Of significance is the finding that all respondents had trust, hope and faith in the church's treatment of their schizophrenia (Manamela *et*

al. 2003: 93). Mental health care services need to be aware of the various spiritual needs of patients with diverse cultural backgrounds, religious ideas, values and worldviews (Koslander and Arvidsson 2007: 598). The following section focuses on this.

2.4 SPIRITUALITY, RELIGION AND CULTURE IN PSYCHIATRIC NURSING CARE

Psychiatric nurses are expected to be culturally sensitive to patients' needs when rendering holistic patient care. Wilson (2010: 720) sought to understand the congruence between psychiatric nursing care and patients' needs in the United States of America. A total of 65 self-administered questionnaires were distributed to psychiatric nurses and 62% were completed. Findings revealed that 92% of respondents understood how African American patients perceived mental illness. Majority of the nurses reported that these clients believed that mental illness is a "curse and a spell". It emerged that 27% of nurses, Caucasian and Asian, lacked knowledge of patients' culture and disagreed that religious or spiritual practices influenced mental illness. Interviews conducted with patients (n=15) revealed that the majority of clients experienced low self-esteem and self-confidence. Prayer was found to be an important aspect of participants' lifestyles. These findings were supported by patients' perceptions that nurses understood and supported their spiritual needs.

In line with patients' spiritual needs, Koslander and Arvidsson (2005: 558) sought to gain a deeper understanding of nurses' perceptions of how the spiritual dimension is addressed in the nurse-patient relationship in Sweden. The main findings of interviews with psychiatric nurses (n=12) showed that nurses should play an active role in the nurse-patient relationship by displaying confidence, trust and offering patients encouragement during recovery. Participants reported that nurses have a duty to be sensitive to the spiritual needs of psychiatric patients. However, findings revealed that nurses avoided aspects related to patients' spiritual needs and coped with this by referring patients to other health care professionals.

Patients' thoughts of how the spiritual dimension is addressed in Swedish mental health care facilities were investigated (Koslander and Arvidsson 2007: 597). Three themes emerged from interviews with patients (n=12). Patients want to have their spiritual needs met, patients must ensure that their spiritual needs are met and patients lacked confidence in the nurses' ability to discuss spirituality. Findings show that patients' mental health improves when nurses attend to the spiritual dimension of caring. Reports indicated that patients experienced inner peace, believed their minds were at ease, felt emotional contentment and held the idea that discussing spiritual matters helped reduce suffering, all of which led to the rapid recovery of patients (Koslander and Arvidsson 2007: 601). In addition, patients reported that they wanted to talk about issues related to spirituality and that talking with nurses revealed that the spirituality of patients was vital to nursing practice (Koslander and Arvidsson 2007: 601). In psychiatric services, nurses are the largest group of professionals providing care on a daily basis. This therefore places nurses at the crucial position of establishing valued nurse-patient relationships (Cameron, Kapur and Campbell 2005: 64).

2.5 THERAPEUTIC COMMUNICATION AND PSYCHIATRIC NURSING CARE

Nursing is therapeutic because it is a healing art and assists an individual who is sick or in need of health care. Nursing and mental health care can be viewed as an interpersonal process, because it involves interaction between two or more individuals with a common goal. In nursing, the latter provides the incentive for the therapeutic process in which the nurse and patient respect each other as individuals, both growing and learning as a result of this interaction (George 2002: 62).

Hildegard Peplau's Interpersonal Relations Theory maintains that humans have physiological, psychological and social attributes and an imbalance of these attributes occurs during illness. Stabilisation of the person is the result of building a therapeutic client-practitioner relationship (Parrish and Peden 2009: 51).

Rask and Brunt (2006: 100) described the nurse-patient relationship as an interactive process of communication which focused on the patient. They sought to

gain understanding of the perceptions nurses and patients held of the frequency of interactive relationships in Swedish forensic wards. Patients and nurses completed questionnaires. Of the patients (n=73) included in the study 27% (n=20) completed the questionnaires. Results indicated that 43% of patients believed that nurses frequently made time for communication and showed patients support during difficult situations in the ward setting. Almost 80% of patients reported that encouraging patients to communicate when faced with a difficult time was important in the nurse-patient therapeutic relationship. Of the nurses (n=127) included in the study, 68% (n=87) completed the questionnaire. Results revealed that 71% of nurses perceived frequent interaction as being supportive and encouraged nurse-patient interaction, whilst 84% of participants believed that this nursing role was important in forensic wards.

Within the therapeutic nurse-patient relationship, nursing roles were to empower patients, families, community members and general nurses in this area of nursing. Building and fostering a trusting nurse-patient relationship with the focus on reducing the stigma of mental illness received attention in this paper. The mental health consultation liaison nurse in Australia has a role to ensure meaningful nurse-patient relationships, or that therapeutic relationships are formed and maintained (Merritt and Procter 2010: 158).

In line with the importance of establishing a therapeutic relationship with patients, O'Neill, Moore and Ryan (2008: 583) explored the views that psychiatric nurses (n=8) have of their roles when caring for mentally ill patients in the United Kingdom. Participants emphasised the importance of supporting each other when difficult situations arise and to work as a team when they encounter problematic patients. It was suggested that there was a need for the development of a therapeutic environment for mentally ill persons.

Similar findings were presented by Timmons (2010: 639), when he described the roles of psychiatric nurses at a high security facility in Ireland. A postal survey of psychiatric nurses (n=101) yielded a response rate of 74%. Findings revealed that 97% of respondents believed that the development of a therapeutic relationship with patients was important and patients' safety was vital in rendering quality psychiatric nursing care. The results also showed that 85% of respondents felt that

they were expected to provide and maintain a therapeutic environment for these patients by considering the needs of patients.

In a study conducted in Australian forensic psychiatric settings, Martin and Street (2003: 546) explored the therapeutic nurse-patient relationship. Interviews with nurses (n=5) indicated that participants identified the nurse-patient relationship as being powerful and related the benefits of therapeutic relationships for patient well-being. Informants used “shared activities” such as sports, listening to music and involvement in other recreational programmes to build therapeutic, trusting, nurse-patient relationships.

Individuals with schizophrenia have difficulty developing social relationships, yet the quality of life of these patients is influenced by their relationships with others. The ability of nurses to maintain verbal and nonverbal interactions with mentally ill patients, whilst creating a therapeutic relationship at a community health care centre in Massachusetts, was described. This inquiry showed that nurses have skills in establishing and maintaining communication with psychotic patients. The results revealed that, despite the acute negative symptoms related to schizophrenia, nurses are willing to interact with these patients (Pounds 2010: 772).

Schizophrenia is a chronic illness which requires long-term rehabilitation. Social rehabilitation groups have been established, viz. social skills training, stress coping skills, art therapy, occupational therapy, entertainment therapy and music therapy, which has shown significant effects in treatment of schizophrenia (Chen, Lin, Sun, Zung, Su, Hsu 2005 cited in Lu *et al.* 2013: 683). Using another approach, the effects of group music therapy on 74% (n=59) of male and 26% of (n=21) female schizophrenic patients with psychiatric symptoms and depression was examined in Taiwan. Of the 420 patients that were assessed, 80 patients were eligible and included in the music intervention group (n=38) and the usual care groups (n=42). After 10 sessions of group music therapy, there were significant differences in the symptoms of patients from the randomised control trial. Results concluded that group music therapy is an economical and easily implemented method of improving depression and psychiatric symptoms in schizophrenic patients (Lu *et al.* 2013: 682). How nurses help people to live with

and overcome distress, or develop themselves so that they begin to overcome and recover from their difficulties, differs from the nurturing approach to human development. While the specific roles and functions may vary, the underlying caring philosophy of nursing has not changed (Barker 2003: 489). The roles, functions and activities of psychiatric nursing care will follow.

2.6 ROLES, FUNCTIONS AND ACTIVITIES OF PSYCHIATRIC NURSES

2.6.1 Roles in psychiatric nursing care

The roles of the in-patient psychiatric nurse has been described as attending to patients' basic needs, administering and monitoring medication, undertaking ward administrative activities, providing health education for patients and ensuring a safe environment for patients and others (Rungapadiachy, Madill and Gough 2004: 719 ; Bowers 2005: 231 ; Seed, Torkelson and Alnatour 2010: 160).

Several studies investigated nurses' perceptions of roles and client care activities in Sweden, New Zealand, Ireland and Taiwan (Berg and Hallberg 2000: 324; Fourie *et al.* 2005: 136; McCardle, Parahoo and Mc Kenna 2007: 179; Huang *et al.* 2008: 3030). These studies showed that nurses' roles were maintaining therapeutic nurse-patient relations, assessment and planning. These researchers found that the psychiatric nurse was a co-ordinator, communicator, supporter, patient advocate, educator and staff supervisor. Cleary and Edwards (1999: 469) made similar findings with their sample of nurses (n=10) and patients (n=10). Interviews revealed that the primary role of the psychiatric nurse was to promote patient independence.

The expected and perceived roles placed demands on the care rendered by nurses. An ethnographic approach was utilized to gain understanding of the perceived roles of nurses in mental health care facilities (Cleary 2004: 53). Interviews conducted revealed that nurses were overworked. Nurses were faced with added responsibilities, viz. accompanying patients being transferred to other wards, electroconvulsive therapy and to other appointments. Participants (n=10) described themselves as being the "backbone" of the unit and felt that they had the responsibility to "keep the unit going" (Cleary 2004: 55).

An investigation of the perceptions of the psychosocial work environment, stress factors and individual characteristics, viz. perceived stress, stress of conscience, moral sensitivity and mastery amongst registered nurses (n=38) and nurses (n=55) at 12 acute in-patient psychiatric facilities in Sweden, was conducted (Tuvesson and Eklund 2014: 1168). Of the 179 questionnaires which were distributed 93 (52%) were completed. Findings suggested that perceived stress, which included role clarity, was most significant. On average, 7.5% of respondents reported a low level of role clarity. These aspects pertained to whether staff understood "what psychiatric nursing is about", the expected work roles and whether or not expectations were communicated clearly, guiding psychiatric nursing functions. Further findings revealed that managers have a responsibility to create a climate which prevents stress, thereby improving the psychosocial environment in areas, viz. organisational climate, role clarity and work control (Tuvesson and Eklund 2014: 1171).

The role of the South African psychiatric nurse is similar to those of psychiatric nurses in other countries. Uys and Middleton (2010: 18) explained that psychiatric nurses found it difficult to conceptualise and explain what their role is. They found that these nurses facilitated the following aspects related to patient care, viz. medication management, serving meals, ensuring patients' physical needs were met, admission, transferring and discharging patients, restraining unmanageable patients and attending to family queries. The psychiatric nurses' fundamental role was a patient counsellor (Uys and Middleton 2010: 18).

Attention has also been given to the reorientation of primary health care nurses' roles and functions in providing comprehensive services, which include the integration of mental health care in South African primary health care facilities. Observation and recording of nurse-patient interactions and interviews with primary health care nurses (n=6) revealed that certain qualities in nurses, viz. personality, attitude and interpersonal skills, promote comprehensive care (Petersen 1999: 910). Mental health nursing roles extend to other health care departments, viz. emergency and general sections, in health care facilities.

2.6.2 Psychiatric nursing roles in emergency and general departments

Nurses working in emergency units care for mentally ill patients who, at times also present with substance abuse problems, acute distress or agitation, with poor mental functioning and altered perception (Camilli and Martin 2005: 313; Nicholls, Gaynor, Shafiei, Bosanac and Farrell 2011: 531; Simpson, Joesch, West and Pasic 2014: 113). The roles and attitudes of the emergency department registered nurse and mental health nurse practitioner at emergency departments in the United States of America and Australia were established (Camilli and Martin 2005: 313 ; Nicholls *et al.* 2011: 531). Patients' length of stay ranged from a few hours to 48 hours in the emergency units. During this period, nurses and other staff required competencies and skills to manage the behaviours these patients displayed. Training and skill development equipped all categories of staff to manage psychiatric patients, improve staff confidence when handling psychiatric patients, and reduced the negative perception which staff had of these patients. Further skill development included de-escalation skills, redirection of aggressive behaviour and assessment of psychiatric patients on admission and care of patients with dual diagnosis (Camilli and Martin 2005: 313; Nicholls *et al.* 2011: 530).

In support of the latter, the risk factors associated with patients experiencing physical restraint or seclusion in psychiatric emergency services was studied (Simpson *et al*. 2014: 113). A retrospective review of all adult admissions at psychiatric emergency services in Seattle, from June 2011 to May 2012, was conducted. Results revealed that 14% (n=646) of 5 335 admissions required restraint or seclusion. The motivations for restraint or seclusion were arrival at the emergency unit in restraints, referral not initiated by the patient, arrival between 19:00 hours and 00:59 hours, bipolar mania or a mixed illness episode, severe disruptiveness, psychosis or poor insight (Simpson *et al.* 2014: 113).

Brown (2007: 475) surveyed the methods used by emergency department psychiatric services, to manage psychiatric patients or patients with substance abuse problems in the United States of America. The study included responses from administrators at 71 hospitals. More than 50% of respondents provided psychiatric emergency consultation services, whilst 39% of respondents did not

offer this service. An open-ended question required respondents' identification of factors influencing the hospitals decision to provide an emergency department psychiatric service. Responses emerged which focused on structural, environmental and organizational factors and perceptions of the feasibility and affordability of such a service. Forty eight percent of respondents believed that the factor which most strongly influenced the decision to provide a functional emergency department psychiatric service was supported by the hospital having an in-patient psychiatric service (Brown 2007: 477).

Twenty five percent of people receiving health care in the United States of America have an existing or previous mental illness. Thus nurses working at emergency departments should be prepared to care for psychiatric patients in these departments (Vierheller and Denton 2014: 49). In a study at emergency departments in the United States of America, the approaches nurses maintain when ensuring staff and patient safety was explored (Vierheller and Denton 2014: 49). Specific abilities were required when caring for and managing psychiatric patients, viz. identification of risks and crisis situations, preparing for the unknown by ensuring adequate staff-patient ratios, maintaining safety measures such as the use of security equipment, viz. panic buttons, and creating a safe physical environment for patients, staff and visitors. Nurses in these departments apply knowledge, training and experience when caring for acutely mentally ill persons and become familiar with the patterns and trends related to mental illness, viz. the demographic groups which contribute towards the growing psychiatric populations. It was found that more than half of the mentally ill patients that presented at emergency departments were males, young or adult, intoxicated with substances, or had a history of medication non-compliance (Vierheller and Denton 2014: 52).

Psychiatric patients in South Africa are being cared for in general hospital wards. Lethoba, Netswera and Rankhumise (2006: 4) probed the perceptions which professional nurses in a general hospital in South Africa held towards caring for psychiatric patients. Of the 170 questionnaires distributed, a total of 124 (72%) were returned. Findings indicated that 76% of male nurses were confident while nursing mentally ill patients, whilst 73% of all respondents believed that these patients were unpredictable. A majority of professional nurses held a positive self-perception of the ability to care for mentally ill patients. However, these

respondents believed that a lack of knowledge, skills and experience negatively affected the care of psychiatric patients (Lethoba, Netswera and Rankhumise 2006: 7). Non-nursing activities, such as increased amounts of administrative duties, limit the amount of time nurses spend with patients and restrict the essential nurse-patient relationship (Cleary and Edwards 1999: 472; Fourie *et al.* 2005: 135). The factors which influence the nurse-patient relationship is dealt with in the section that follows.

2.7 FACTORS WHICH INFLUENCE PSYCHIATRIC NURSING CARE

Cleary and Edwards (1999: 469) explored the factors which promote or hinder the therapeutic nurse-patient relationship at Australian acute psychiatric in-patient facilities. The six themes outlined in interviews of nurses (n=10) were related to the physical environment, patient unpredictability, nurses lacking confidence in this area of speciality and constant measures to foster positive staff team-spirit. Acute patients required more frequent observation and individualized patient care. Activities which hinder interaction between the nurse and the patient were clerical duties, including record-keeping, answering phone calls and co-ordinating patient appointments and activities of other professionals. Findings of interviews with patients (n=10) showed that the nurses were understanding, empathetic and always available to talk with patients. However, some respondents believed that nurses were over-worked, short staffed, experienced increased patient admissions and attributed these factors to the unavailability of nurses to interact with patients.

The perceptions that registered psychiatric nurses held of their actual roles, in comparison to the reality of nursing care at in-patient psychiatric facilities, were investigated in New Zealand (Fourie *et al*. 2005: 134). The activities and functions of registered psychiatric nurses at three selected wards were observed and recorded. Two focus group interviews with participants (n=5) in each group were conducted. Results showed that many of the nursing roles were associated with nursing care from a crisis management approach. These aspects included patient assessment, stabilisation of mental illness symptoms and discharge planning. Participants reported that therapeutic nurse-patient interaction as a role is fundamental in nursing care. However, this role was regarded as challenging at a

busy in-patient unit. Administrative tasks and organisational duties are important, however these duties are time-consuming, resulting in nurses spending less time interacting with patients (Fourie *et al.* 2005: 139). To attract new nurses and retain those currently working in acute psychiatric facilities, it is essential that the psychiatric nurse's role and nurses' satisfaction levels are examined.

2.8 JOB SATISFACTION AND PSYCHIATRIC NURSING CARE

Aspects related to the role of the in-patient psychiatric nurse and their effects on job satisfaction were assessed in the United States of America (Seed, Torkelson and Alnatour 2010: 160). Observations of psychiatric nurses (n=73) confirmed that nurses spent almost two hours per shift doing clerical duties, recording in patients' files, admissions and discharges. This was followed by the time spent communicating with members of the health team. It was reported that nurses spent the least amount of time teaching patients' symptom management. Findings implied that nurses were satisfied when more time was devoted to patient care activities.

Using another approach, gender differences between male (n=28) and female (n=45) psychiatric nurses at in-patient facilities in the United States of America focused on job performance and job satisfaction levels (Torkelson and Seed 2011: 34). Observations and a self-rated questionnaire showed that female nurses spent significantly more time creating therapeutic relationships with patients, whilst some nurses spent no time on this role (range = 0 to 129.89 minutes, mean = 21,28 SD =23.57). Findings also suggested that male nurses who were not comfortable with the caring role of nursing chose this area of speciality, because psychiatric nursing involved task-orientated or masculine duties, which would justify almost 40% of the sample being male (Torkelson and Seed 2011: 39). The factors which influence readmissions, management of physical and mental illness and the common types of behavioural and clinical problems will be discussed.

2.9. THE TYPES OF BEHAVIOURAL AND CLINICAL PROBLEMS PSYCHIATRIC NURSES ENCOUNTER IN PRACTICE

2.9.1 Readmission of psychiatric patients to these facilities

Recurrent admission of people with schizophrenia is increasing and this places a strain on health care services in Nigeria. The factors that contribute to the readmission of patients were investigated by Bimerew, Sonn and Kortenbout (2007: 80). Of the 46 randomly selected participants only 43 were surveyed. These surveys were excluded from the study since they were incomplete. Survey results revealed that 41% of respondents stated that they use “khat” (a plant grown in Ethiopia which has psycho-stimulant effects). Results showed that 25% (n=11) of respondents abused alcohol. Focus group discussions with family members or caregivers (n=14) revealed that people with schizophrenia abuse alcohol and other substances, which is a contributing factor toward the frequent readmissions. They reported that these substances were the greatest obstacles to providing care for these persons. It emerged that withholding these substances often resulted in these persons becoming aggressive and violent (Bimerew, Sonn and Kortenbout 2007: 74).

Neuropsychiatric conditions were rated third on the scale measuring the disease burden in South Africa, followed by HIV and AIDS (Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome) and other infectious diseases. Reports showed that between 2002 and 2004, 16.5% of adult South Africans presented with common mental disorders (Lund *et al*. 2010: 394). Janse Van Rensburg and Olorunju (2010: 204) similarly investigated the clinical profile of patients with schizophrenia at a general hospital-based acute psychiatric ward in Johannesburg. The study aimed at identifying possible associated or predictive factors in acute in-patient treatment. Routine discharge summaries of schizophrenic patients were reviewed retrospectively. Findings revealed that there were patterns of repeated readmission of the same patients. This is commonly known as the revolving door phenomenon, which frequently results from the fragmentation of regional community psychiatric services and the discontinuity of care and treatment of patients after discharge from acute units. It was discovered

that 436 patients were diagnosed as schizophrenic, contributing to 20% of the number of admissions (Janse Van Rensburg and Olorunju 2010: 206).

Botha, Koen, Joska, Parker, Horn, Hering and Oosthuizen (2010: 461) concurred with these findings, when investigating the factors which affected patients' (n=146) trends of readmission rates or the revolving door phenomenon. Findings confirmed that 34% of participants who were termed high-frequency users showed a history of poor medication compliance. In contrast, 62% of participants who were termed low-frequency users received the injectable antipsychotic treatment. It was established that the use of the injectable form of treatment was a major distinguishing factor between reasons for recurring admissions in psychiatric in-patient facilities and contributed to psychiatric patients' compliance to medication.

2.9.2 Mental ill-health and physical illness (dual diagnosis)

Rendering nursing care to patients with physical and psychological problems has become a common occurrence (Happell and Platania-Phung 2005: 42).The treatment of psychiatric patients with a medical illness in general psychiatric facilities in closed wards is expected in Japan (Hatta, Usui, Nakamura, Kurosawa and Arai 2010: 52). This study investigated whether open wards compared with closed wards of general hospitals is needed for the treatment of patients with medical comorbidities. Of the patients (n=520) admitted to open ward facilities during the study period, 15% (n=77) presented with physical and mental illness. Of the total number of patients (n=477) admitted in locked or closed ward facilities, 20% (n=97) of patients were admitted with psychiatric illness and physical illness. Findings indicated that locked or closed ward facilities were the preferred environment for the management of patients with physical and mental conditions, in comparison to open wards.

Nurses in South Africa care for psychiatric patients who have a dual diagnosis of HIV and AIDS or another physical illness and a mental illness. HIV and AIDS had an effect on mental illness. Psychiatric disorder, namely depression, is common in patients diagnosed with HIV (Uys and Middleton 2010: 715; van Dyk and van Dyk 2012: 204,224). Myer, Smit, Le Roux, Parker, Stein and Seedat (2008: 147)

undertook a study with patients enrolled in HIV care and treatment services, to gain knowledge about the prevalence of mental disorders and HIV infection in sub-Saharan Africa. Fourteen percent (n=62) of respondents were depressed, 5% (n=24) of respondents reported post-traumatic stress disorder and 7% (n=35) of respondents were alcohol and substance dependent. The report maintained that mental health disorders were prevalent amongst HIV and AIDS patients.

The degree of depression and anxiety symptoms in persons living with HIV and AIDS was studied among South African adults (n=85) attending public health clinics (Kagee and Martin 2010: 159; van Dyk and van Dyk 2012: 204,224). More than 50% (n=47) of respondents reported symptoms, of psychological distress and anxiety. Twenty four percent (n=21) of respondents were mildly to moderately depressed, while 20% (n=17) of respondents reported moderate to severe depression. Seventeen percent (n=15) of respondents were severely depressed.

2.9.3 Behavioural problems and clinical conditions

Many people with a mental illness are cared for in the community. However, there are individuals who need intensive psychiatric care, which is provided at in-patient psychiatric facilities. Wynaden *et al*. (2001: 843) sought to gain a deeper understanding of statistics related to patient diagnosis, signs and symptoms, behaviours and treatment plans for psychiatric in-patients in Australia. Data collected from 122 patients' files showed that the most common diagnostic categories were paranoid schizophrenia (22%), hypomania and bipolar disorder (14%), depressive mood disorder (9%) and delusional disorder (7%). Nine percent (n=11) of patients presented with more than one diagnosis in this study. The presenting signs, symptoms and behaviours were paranoid and delusional symptoms (10%), aggressive behaviour (8%) and psychotic and manic behaviour (6%).

The potential for violence in acute psychiatric patients is of significant concern in psychiatric wards. Chen, Hwu and Williams (2005: 141) investigated psychiatric nurses' levels of anxiety, attitudes, cognition and their need for training in management of aggressive psychiatric patients in Taiwan. Of the 214 self-report

questionnaires which were distributed, 209 (98%) were completed. Findings revealed that 86% (n=180) of nurses experienced patient aggression, whilst 14% of respondents reported having no experience with patient aggression. More than 17% (n=31) of respondents experienced verbal aggression and 27% (n=49) of participants were exposed to physical aggression. Almost half (n=98) of the participants experienced verbal and physical aggression. There were significantly higher levels of anxiety amongst nurses when patients became either verbally or physically aggressive. A need for education and training in the management of aggressive patients was suggested.

In a study conducted in Chinese psychiatric hospitals, the frequency of violence, risk factors and the impact of violence on the quality of life of nurses was examined (Zeng, An, Xiang, Qi, Ungvari, Newhouse, Yu, Lai, Yu, Ding, Tang, Wu, Hou and Chiu 2013: 511). Of the 392 surveys distributed, 387(99%) were completed. Results showed that 82% of respondents reported exposure to at least one type of violence in the past six months. A further 78% (n=304) of respondents experienced verbal threats. Survey responses showed that 61% (n=238) of respondents were exposed to physical threats or abuse. Twenty four percent (n=96) of respondents reported verbal sexual assault, whilst 16% (n=62) revealed incidents of physical sexual assault. It was concluded that nurses who were exposed to violence experienced a lower quality of life in physical and mental aspects in their personal life (Zeng *et al*. 2013: 510).

2.10. THE CHALLENGES FACED BY PSYCHIATRIC NURSES WHEN CARING FOR PSYCHIATRIC PATIENTS

2.10.1 The psychological effects of working with psychiatric patients

Caring for patients who are demanding, difficult and threatening increases staff anxiety and stress levels. Jenkins and Elliott (2004: 626) investigated and compared nurses' levels of stress and burnout at acute in-patient mental health settings in the United Kingdom. A convenience sample of qualified nurses (n=57) and nursing assistants (n=36) was chosen from 11 wards at four identified facilities. Of the 240 questionnaires which were distributed, 93 (39%) were

completed. Results were reported according to the nursing categories; 53% (n=30) of qualified nurses and 50% (n=18) of nursing assistants reported high levels of emotional exhaustion and “depletion or draining of one’s emotional resources”. Forty one percent (n=15) of nursing assistants and 35% (n=20) of qualified nurses reported high levels of depersonalisation, which is the development of negative, callous and cynical attitudes towards patients (Maslach and Jackson 1981 cited in Jenkins and Elliott 2004: 625).

Cleary (2004: 55) sought to understand the realities of mental health nursing at acute in-patient facilities in Australia. Observation was used to identify the activities of nurses in a 22-bed admission ward. Interviews were conducted with nurses (n=10) which revealed nurses were overworked and spent more time with patients than any other health-care worker. Nurses commented on the “unpredictability of the work environment” and reported feeling emotionally exhausted (Cleary 2004: 55).

Aspects of staff behaviour may influence aggression encounters with in-patients. Martin and Daffern (2006: 90) sought to identify the factors which contributed to clinicians’ perceptions of safety and confidence at forensic in-patient settings in Australia. Of the 125 questionnaires distributed, 55% (n=69) were completed. The factors that impacted on clinicians’ confidence to manage aggressive patients was co-workers confidence, knowledge, experience and the ability to apply prevention techniques when faced with aggressive patients.

The prevalence of aggressive behaviour of patients toward nurses in the first year of practice and the psychological effect of this behaviour was investigated in New Zealand (Mc Kenna, Poole, Smith, Coverdale, and Gale 2003: 56). A total of 1 169 surveys was distributed and 551 were returned, yielding a response rate of 47%. The most common inappropriate behaviour displayed by 35% (n=192) of patients were verbal threats, 30% (n=167) of patients showed verbal sexual harassment and 29% (n=161) of patients were reported as being physically intimidating. There were 22 incidents of assault which required medical intervention and 21 reported incidents of patients stalking participants. Findings indicated a need to prioritize effective prevention programmes and a need for undergraduate nursing curricula to address these issues in the training and development programme.

In a study in Turkey, Talas, Kocaöz and Akgüc (2011: 197) supported the need for nurse training and development at in-patient psychiatric facilities. The study aimed to identify the proportion of staff subjected to different types of violence, its sources, the factors affecting violent experiences, reporting of the incidents and the emotions of victims following violence. Results showed that 85% of participants had been subjected to at least one kind of violence; 41% to physical assault, 79% to verbal abuse, 55% to verbal threats and 15% to sexual harassment. The researcher concluded that training to deal with these multiple difficult experiences should be available as part of on-the-job training for staff.

In line with the demands of working at a psychiatric facility, van der Colff and Rothmann (2009: 4) assessed the relationship between occupational stress, sense of coherence, coping, burnout and work engagement of registered nurses in South Africa. This cross-sectional survey of registered nurses (n=818) included 3% (n=25) of nurses from mental health care facilities. Results revealed that nurses experienced a depletion of emotional resources and feelings of depersonalization, which were associated with stress due to job demands and a lack of organizational support.

2.10.2 Physical safety of psychiatric nurses in psychiatric settings

Psychiatric nursing roles have changed significantly. Nurses are expected to care for people with serious and long-term mental illness in the community. Gournay (2005: 6) investigated the implications of change within psychiatric nursing and the impact it had on nursing care. Community psychiatric nurses in the United Kingdom have directed nursing care towards people with serious mental illness. Psychiatric nursing roles have evolved and nurses are expected to care for dangerous patients, as well as those presenting with severe personality disorders. These changes in psychiatric nursing require the improvement of skills in areas viz. the physical care of patients, medication management, including nurses prescribing medication, and training in the use of psychosocial interventions.

Research by Chen, Sun, Lan and Chiu (2009: 2812) supported these findings. These scholars sought to determine the incidence and risk factors of workplace

violence towards psychiatric nurses at in-patient facilities in Taiwan. A total of 971 incidents were reported; physical violence (1%), verbal abuse (3%), bullying or mobbing (0.2%) and sexual harassment (0.3%). Young females with lower levels of nursing education, a shorter duration of employment and high levels of anxiety were determinants of violence. It was suggested that pre-placement education may reduce workplace violence.

Inoue *et al.* (2006: 31) surveyed the psychological impact verbal abuse and violence has on nurses at psychiatric settings in Japan. Surveys distributed to nurses (n=266) yielded a response rate of 61%, showing that these nurses had been exposed to verbal abuse and violence. An area of importance which emerged was that nurses gave attention to their own mental wellbeing and colleagues, prior to caring for patients. Nurses needed the positive support of family and significant others when faced with challenges in the workplace. Respondents displaying increased neuroticism and emotional instability were identified in advance and psychological support offered. The results revealed that these individuals were more susceptible to psychological trauma.

In a different light, Inoue, Kaneko and Okamura (2011: 2) evaluated the effectiveness of an intervention group approach aimed at improving the mental health of psychiatric nurses caring for violent and aggressive patients in Japan. A random selection method was employed for the intervention group (n=30), whilst the control group consisted of 32. The intervention group focused on topics, viz. stress management, strategies used when faced with patient violence and behavioural problems and relaxation and image therapy. Investigations revealed that there was a need to review the way nurses handled patients or their emotions towards these patients, especially following an aggressive or violent episode. Participants were encouraged to verbalize their feelings after traumatic incidents. They expressed feelings of confidence when faced with future violent situations, behaviour problems and reported alleviation of anxiety and depression, following intervention strategies such as relaxation techniques.

Bowers, Crowhurst, Alexander, Callaghan, Eales, Guy, Mc Cann and Ryan (2002: 427) sought to understand the safety and security policies at acute psychiatric admission wards, using a survey in the United Kingdom. Questionnaires were

distributed to 124 respondents, of which 87 were completed. This reflected a response rate of 70%. Contrasts between participant agreement about safety and security measures were identified, which were related to security operational protocol, firstly the prevention of harm to patients by using security doors and restricting certain dangerous items. Other security measures minimized incidents when patients were searched, when security services were used and when alarm systems were installed. Significantly, items which were restricted in one facility were unbanned in the other facility.

It has been found that nurses caring for patients at acute psychiatric facilities were at risk of sustaining injuries while restraining patients. Moyo and Robinson (2012: 5) investigated the patterns, types and occurrences of injuries nurses sustained while restraining aggressive patients at acute in-patient settings in Australia. There were two phases used for data collection. Thirty two nursing incident reports were reviewed and analysed in phase one. Questionnaires were utilized to collect data for phase two of the study. Of the 33 questionnaires distributed, 30 were completed, which reflected a response rate of more than 90%. Findings of phase one indicated that 37% of nurses were injured during the afternoon shift, whilst holding the patient in a stage of restraint. A further 80% of nurses sustained multiple injuries while restraining patients. The results which emerged from phase two of the study suggested that restraining aggressive patients was linked with increased risk of injury (25%), with the proportion of injuries to females (52%) being higher than males (28%). This study also included open-ended questions, which explored the factors respondents believed would improve safety during the restraining process. Results revealed that team co-operation was needed during the restraining process. The researcher recommended the following: the commencement of user-friendly and easier restraining techniques and an extension of the training period for nurses. The challenges encountered locally will follow.

Hostile and aggressive behaviour is becoming a way of life in South Africa and is found in all settings, including health care environments (Bimenyimana *et al.* 2009: 5;Tema, Poggenpoel and Myburgh 2011: 915). In line with the safety of psychiatric nurses in health care settings, Tema, Poggenpoel and Myburgh (2011: 917) explored psychiatric nurses' (n=9) experiences of hostile behaviour at forensic

environments in a facility in Gauteng. In-depth phenomenological interviews revealed that nurses were exposed to stressful work conditions, resulting in this group of nurses feeling disempowered, fearful, emotional and distressed. Female participants reported that at times they were bullied by patients. One of the participants stated “while I was writing during an interview, he slapped me on the cheek … commanded me to stop writing, I shouted for help, other patients came to rescue me”. These results revealed that the nurses’ ability to maintain therapeutic relationships with patients in forensic environments was hindered. Overall findings showed that caring for patients at forensic units is stressful and is disempowering and a challenge to the mental health of this group of nurses.

Lethoba, Netswera and Rankhumise (2006: 4) described professional nurses’ perceptions of nursing mentally ill patients at a public general hospital setting in Gauteng. Questionnaires were distributed to professional nurses (n=170) of which 124 were completed. This showed a response rate of 72%. Findings of nurses’ self-perception of caring for mentally ill patients reflected that 76% of male nurses were confident about nursing mentally ill patients. Respondents aged 25 to 35 (65%), 35 to 44 (58%) and 45 to 54 (60%) reported feeling less confident to create and maintain a therapeutic relationship with mentally ill patients. In contrast, all respondents aged 25 and below stated that they were confident in this aspect of caring for these patients. Results of nurses’ perception of patients indicated that over 50% of respondents reported that these patients were attention-seeking and 73% of patients were unpredictable. Sixty five percent of female respondents believed that this group of patients were difficult to care for, especially if they wandered away from the ward. Similar beliefs were held by 53% of male respondents.

2.10.3 Experiences of psychiatric nurses

Berg and Hallberg (2000: 324) explored psychiatric nurses lived experiences of working with psychiatric patients in general settings in Sweden. Narrative interviews of psychiatric nurses (n=22) illustrated three main themes, developing a working relationship when caring for these patients, coping with unpredictable patient behaviour and having greater patient responsibilities with limited decision-making ability in patient care.

A multinational survey of 999 psychiatric nurses, working in psychiatric facilities across the United States, Canada, the United Kingdom and South Africa was conducted by Poster (1996: 365). She inquired about beliefs and concerns in the workplace, nurses' safety and assault by patients. Seventy five percent of the sample reported being physically assaulted at least once during their careers. However, 62% of respondents felt safe most of the time.

In Swiss hospitals, different findings were made. Hahn, Müller, Needham, Dassen, Kok, Halfens (2010: 3535) conducted a retrospective cross-sectional survey to explore nurses' experiences with patients and visitor violence. The study found that 72% of nurses had experienced verbal patient and visitor violence and 42% physical patient and visitor violence in the past 12 months. Nurses caring for anxious and cognitively impaired patients were found to be more at risk of patient assault.

Psychiatric nursing research studies in South Africa revealed that caring for physically ill patients is a difficult task. Rendering psychiatric nursing care to mentally ill patients can be challenging (Bimenyimana *et al.* 2009: 5). Ngako, van Rensburg and Mataboge (2012: 2) made similar findings in their study, which explored psychiatric nurse practitioners' experiences of working with acute psychiatric patients at a facility in Gauteng. Focus group interviews with psychiatric nurse practitioners (n=21) revealed that the environment was unsafe; participants had negative emotional reactions and attitudes towards these patients. Further reports indicated that these factors compromised the nursing care offered to patients.

Mavundla's (2000: 1569) study concurred with these findings. His study gained deeper understanding of the experience of nursing mentally ill patients at a hospital in Durban. Through in-depth qualitative interviews with professional nurses(n=12), he found a perception that nursing mentally ill people in a general hospital setting was negative and affected the intellectual and affective component of the nurses' psychological functioning within their internal environment.

Student nurses require knowledge and experience in nursing specialities, which will prepare these nurses with skills to provide comprehensive patient care. Van Rhyn and Gontsana (2004: 23) established similar findings in a study which

investigated student nurses' (n=8) experiences during clinical placements at a psychiatric department in the North West Province. It emerged that all participants experienced average to high stress and felt less confident caring for these patients. Further results showed that participants (n=5) stated that they were "miserable" and felt "discouraged" because of other staff's negative attitudes (Van Rhyn and Gontsana 2004: 23). Attitudes, beliefs and stigma related to mental illness will be discussed in the following section.

2.10.4 Attitudes, beliefs and stigma related to mental illness

Attitudes were described as general feelings, either negative or positive, which a person has towards self, others, objects or events (Louw and Edwards 1997: 748). A positive attitude towards mental illness has been found to be important in psychiatric nursing care and assists patients in rehabilitation. Munro and Baker (2007: 198) surveyed the attitudes of nurses (n=140) working at acute mental health settings in the United Kingdom. More than 55% of questionnaires were completed. Findings revealed that 80% of this sample had positive attitudes towards mental illness. More than 95% of respondents said that psychiatric illness deserved equal attention as medical illnesses.

Mental disorders are rated fourth out of the 10 foremost causes of disability globally, and are predicted to be the second leading cause of illness by 2020. Thirty one percent of the total disability and 12% of the total disease burden in the world are attributed to mental illness. However, mental health services in developed and developing countries are not given priority and are often neglected, marginalised, stigmatised and isolated from mainstream health services (WHO 2001 cited in Zolnierek 2008: 563). A review of policy development and care approaches to address mental health needs and the global integration of care was undertaken (Zolnierek 2008: 562). Integration of these services aimed at prioritising issues, viz. accessibility of psychiatric services to all persons, removal of stigma and the marginalisation of mental illness. Reiss-Brennan (2004 cited in Zolnierek 2008: 564) described integration as managing mental-ill health in the same way as any other medical condition. The integration of health care services

required holistic patient care, with emphasis on physical, social, mental and cultural aspects.

The provision of effective mental health care is influenced by psychiatrists and mental health care nurses understanding each other's beliefs and expectations when managing patients (Caldwell and Jorm 2000: 602). Professionals caring for psychiatric patients shared similar beliefs about the treatment and management of schizophrenic and depressed patients. Mental health nurses beliefs of caring for schizophrenic and depressed patients in relation to psychiatrists and members of the public were investigated. Of the 980 postal surveys distributed, 70% (n=673) were completed. Findings indicated that the majority of mental health nurses and psychiatrists ranked seeking nursing and psychiatric interventions, antipsychotic treatment and admission to a psychiatric unit as most helpful for these patients. Alternatively, members of the public and nurses believed interventions, viz. socializing, increasing physical activity, relaxation exercises, nutritional diets and psychotherapy were valuable for these patients (Caldwell and Jorm 2000: 605).

Nurses spend more time in direct contact with psychiatric patients who are psychotic in comparison to other health care professionals. Psychosis is a severe mental state characterised by loss of reality and impaired mental functioning. It causes deterioration of normal social functioning and reduces the person's ability to cope with life's demands (Lesinskiene, Jegorova and Ranceva 2007: 759). The work environment, attitudes, needs and emotional attributes of psychiatric nurses (n=152) caring for young psychotic patients at 15 facilities in Lithuania was analysed (Lesinskiene, Jegorova and Ranceva 2007: 758). A total of 152 questionnaires were distributed. Eighty six were completed, showing a response rate of 76%. The inquiry suggested that more than 50% (n=44) of nurses cared for more than 100 psychotic patients during their clinical experience. Whilst a majority of the nurses stated that they were fully satisfied with their jobs, more than 40% of respondents stated that they were concerned about the safety of nurses and patients.

Bilgin (2009: 252) investigated whether or not staff attitudes and behaviours were related to the assault of nurses at psychiatric settings in Turkey. All the psychiatric nurses (n=162) who were selected for the study completed the information form.

Findings revealed that nurses who are less sociable and with lower tolerance are more exposed to physical assaults from patients, whilst nurses who are more help-seeking are more exposed to verbal assaults. These findings suggested that nurses' interpersonal styles and attitudes may contribute to aggressive behaviour of patients and their relatives.

In support of reducing stigma, negative attitudes and beliefs concerning mental illness, public health education campaigns, which explained the causes and treatment of mental illness, needed strengthening in South Africa. Hugo, Boshoff, Traut, Zungu-Dirwayi and Stein (2003: 715) studied the attitude, causes of mental illness and the treatment choices of South Africans. Of the 667 selected subjects, 638 (95%) completed the questionnaires. Surveys of members of the public revealed that 76% of participants believed that the causes of mental illness were stress-related emotional problems (67%) and relationship problems were 63%. Participants perceived that schizophrenia (81%) and panic disorder (83%) were caused by stress. Further findings showed that 84% of participants believed that the most appropriate treatment for mentally ill patients was to talk with someone, whilst 54% of respondents felt that patients should seek treatment at a local clinic.

Jack-Ide,Uys and Middleton (2013: 6) sought to investigate the experiences of mental health nurses in providing mental health care services, by understanding the policy implications, identifying the difficulties and challenges encountered when caring for mentally ill persons at an in-patient psychiatric facility in Nigeria. The two domains identified were context and resource domains. Within the first domain, in-depth interviews with males (n=10) and females (n=10) suggested that mental health care professionals were stigmatised and discriminated against at institutional, professional and public levels. It emerged that stigma and negative attitudes towards mental illness resulted in a lack of interest in psychiatric nurse training, which subsequently led to a lack of adequate staffing. The majority of participants reported that, whilst other health care facilities were being renovated, psychiatric facilities were not included, which further suggested that psychiatric services in Nigeria lacked importance. Interviews showed that a lack of resources in financing, human resources, physical or infrastructural capital, medication budget and social support funding created the difficulties and challenges of providing mental health services. All the participants indicated a need for

information and education about the identification of mental illness and the location of mental health services. This supports the need for education and development in this field of nursing. The following section deals with the preparedness, competencies and development of psychiatric nurses in practice.

2.11 PREPAREDNESS, COMPETENCIES AND DEVELOPMENT OF NURSES IN THIS AREA OF SPECIALITY

2.11.1 Training and development

Continuing nursing education and training in acute psychiatric facilities improves nurses' practice (Moschovopoulou, Valkanos, Papastamatis and Giavrimis 2011: 372). The training needs of psychiatric nurses (n=70) at acute wards were investigated in Greece. Findings confirmed that 40% (n=28) of participants required training and development in practical skills. Areas of development were identified in order of priority, viz. management of violent and aggressive behaviour (23%), risk assessment (18%) and care of suicidal patients (16%). Other training needs included management of psychotic patients, communication and assessment skills.

In support of the need for continuing education in nursing, Happell, Palmer and Tennent (2011: 901) explored the skills and attitudes of mental health nurses in Australia. Interviews with mental health nurses (n=10) identified the areas which required development in psychiatric nursing. These were autonomy and self-directedness, confidence in nursing care, listening skills, assertiveness, team work and promotion of holistic patient care in psychiatric nursing.

Happell and Platania-Phung (2005: 41) investigated the prevalence of mental illness within the general health care population in Australia. Findings revealed that caring for patients holistically in nursing is essential. Their study suggested that nurses in general lacked confidence and competence in providing for the biological, social and psychological needs of patients.

Sharrock (2006: 9) articulated the need for education in psychiatric nursing in Australia. He emphasised the need for competence of nurses in general health

care settings when caring for mentally ill patients. His study suggested that nurses lacked confidence when caring for patients with mental health problems in medical and surgical settings. He emphasized the need for a holistic framework at undergraduate level and application in practice, whereby nurses were striving for competence in areas of mental health care.

In line with the need to build competence, Jones and Lowe (2003: 5) focused on skill development for mental health nurses. She sought to determine the training needs of qualified mental health nurses at acute in-patient psychiatric settings in the United Kingdom. Of the 2 000 surveys distributed, 874 questionnaires were returned, however 27% (n=235) were completed. Focus groups and a survey to collect data found that mental health nurses (n=24) required further education and training. Eighty nine percent of respondents said that they would like further post-registration training in aspects related to acute mental health nursing. The areas identified were risk assessment, dealing with personality and psychotic disorders, aggression and violence, substance-related mental illness and psychosocial issues.

Similar findings were obtained by Allen (2013: 40). A re-examination of workplace violence at acute psychiatric settings in the United Kingdom was conducted, following the implementation of the “staying safe programme”. Mental health care workers and nurses (n=245) participated in 20 discussion classes and updates. A review of hospital staff assault reports between May and December 2008 was conducted. Participants reported that “getting hurt is not part of the job” and suggested that the programme be included in all employee orientation programmes and refresher courses. Of significance were a noticeable decrease in the number of staff assaults and an increase in staff requests for help. Results suggested a decrease of staff assaults by 64%. The total numbers of staff assaults in 2007 were 337, whilst in 2012, 122 staff assaults were reported (Allen 2013: 40).

Rendering safe and quality nursing care required that nurses have theoretical and practical knowledge and sound cognitive abilities (Gilje, Klose and Birger 2007: 522). The perceptions held by experienced psychiatric nurses of undergraduate psychiatric nurses in Alaska were investigated. Questionnaires were distributed to respondents (n=19), of which 95% were completed. Ninety eight percent of

respondents emphasized that there were eight clinical competency areas relating to knowledge, skill and attitude and that students were expected to display proficiency in the application of these competencies.

In support of student nurses, an evaluation of a teaching learning strategy aimed at decreasing stress and anxiety during the psychiatric mental health clinical nursing experience in New York was conducted (Ganzer and Zauderer 2013: 245). A self-reflective workshop with student nurses (n=30) revealed that student nurses felt nervous, afraid and anxious. “I am nervous because I don’t know what to expect but hope it is a good experience”. Aspects related to personal safety were verbalised and concerns were raised about being injured by unpredictable and unmanageable patients. Another aspect which student nurses raised was a feeling of being “restricted from coming and going freely in a locked up unit”. Concerns related to the availability of exit door keys were verbalised, since students experienced anxiety when doors were locked and asked “will the professor have a key” (Ganzer and Zauderer 2013: 245).

In further support of the need to strengthen psychiatric nurse education, Adejumo and Ehlers (2001: 215) undertook a comparative study in Botswana and Nigeria. Psychiatric nursing education in mental health care facilities was explored and described. This study conducted an examination of the psychiatric mental health nursing education programme. Questionnaires were distributed to respondents (n=79) from Nigeria, whilst Botswana received a total of 12. Ninety one (69%) questionnaires were completed. Focus group discussions were held with Nigerian (n=8) and Botswana participants (n=5). Findings revealed that psychiatric mental health nursing education programmes needed to prioritize the mental health needs of the people from these countries and focus on the provision of quality nursing care.

Newly qualified nurses lacked experience and competency to manage psychiatric patients. Khoza and Ehlers (2000: 50) investigated the competencies of newly qualified nurses as perceived by senior professional nurses (n=29) at psychiatric units in the Northern Province of South Africa. Descriptive surveys revealed that 75% of newly qualified nurses required supervision and guidance in this field of nursing; 86% of participants reported that these nurses made blunders in everyday

practice. Findings also showed that 79% of newly qualified nurses display competency in caring, whilst 82% showed competency in interpersonal skills. Forty percent of newly qualified nurses displayed competency in admission and discharge procedures, whilst 10% of newly qualified nurses displayed competency in managing a crisis situation in the clinical area.

2.12 CONCLUSION

This chapter reviewed both global and local literature on psychiatric nursing, caring for psychiatric in-patients and the types of behavioural and clinical conditions in nursing practice. Literature related to the challenges encountered and nurses' educational preparedness when caring for psychiatric in-patients was also reviewed. Aspects included in the review were holistic care in psychiatric nursing, spirituality, religion and culture, therapeutic communication and psychiatric nursing care. Chapter 3 will discuss the research methodology of the study.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter provides an overview of the research methodology used to conduct the study. The research design will be highlighted and the sample and population delineated. The data collection tool, data collection process, analysis of data and ethical considerations involved in the study will be discussed. This study utilised primarily the quantitative approach and also elements of qualitative methodology.

3.2 RESEARCH METHODOLOGY

3.2.1 Research design

A research design is the overall plan, prepared in advance for obtaining answers to the research problem. It assists the researcher to attain the intended objectives and may act as the “overall plan for addressing a research question” (Polit and Hungler 1991: 467). The research design explains the strategies and methods the researcher plans to adopt to ensure information obtained is accurate and interpretable (Polit and Hungler 1991: 153; Creswell 2009: 3). Polit and Beck (2012: 58) wrote that a design indicates how often data will be collected; the types of comparisons made between variables and identifies the research setting. Creswell (2009: 5) said that a research design is the plan or proposal to conduct a study, incorporating the researcher’s philosophy and world view, the strategy used for conducting the inquiry in relation to the world view and specific data collection methods utilised to translate the approach into practice.

PHASE ONE

3.2.2 Quantitative research design

Quantitative research approach has its roots in logical positivism and places emphasis upon measurable aspects of human behaviour (Brink 2002: 12). A

quantitative research design is a systematic, orderly and logical plan which aims at finding a solution to the identified problem (Rubin and Babbie 2001 cited in de Vos, Strydom, Fouché and Delport 2011: 143; Polit and Beck 2012: 13). The design reflects decisions taken in relation to the population, sample, data collection process, data collection tool and analysis strategies used in the study. Polit and Beck (2012: 14) added that evidence obtained for quantitative studies sought to gain an understanding of a particular occurrence in humans generally, instead of in specific individuals.

Quantitative research is the study of research questions which described phenomena, tested relationships, identified differences and tried to explain the cause and effect relationship between variables (Creswell 2009: 15 ; Lo Biondo-Wood and Haber 2010: 8). Numerical data gathered from instruments is coded, through a process of translating verbal data into numerical form, thus facilitating statistical analysis of data (Creswell 2009: 4; Lo Biondo-Wood and Haber 2010: 8; Polit and Beck 2012: 14). Quantitative research focuses on specifically defined concepts which reflect the interrelations of the researcher's ideas. Data is collected using formal instruments and control measures are implemented to prevent bias and maintain objectivity during the data collection and analysis process. Numerical information is analysed using statistical procedures (Brink 2002: 13).

Maree and Pietersen (2007 cited in de Vos *et al.* 2011: 144) identified two categories of quantitative research, experimental and non-experimental designs. Non-experimental researchers are described as "bystanders", collecting information without involvement in the data collection process (Polit and Beck 2012: 55). A non-experimental descriptive design was chosen for this study, as most nursing studies are non-experimental and study human characteristics (Polit and Beck 2012: 223).

Burns and Grove (2009: 238) explained that descriptive designs are utilised in areas where limited research has been conducted and are administered in the participants' natural environment. This design offers the researcher ways of identifying new meanings to situations, describing current situations, determining the frequency of events and categorising collected data (Burns and Grove 2009:

237). Descriptive research aims to observe, describe and document attributes of a specific situation as it naturally unfolds and sometimes provides the basis for theory development (Polit and Beck 2012: 226).

A survey was chosen as the data collection technique. Self-report questionnaires were used as the instrument for obtaining the information used for the survey about an identified population (Burns and Grove 2009: 245). The utilisation of questionnaires in surveys is beneficial, since data is collected from large samples; exploring many areas, viz. factual data, attitudes, beliefs, prejudices or opinions of the participants (Polit and Hungler 1991: 174; Lo Biondo-Wood and Haber 2010: 199; Monette *et al*. 2008 cited in de Vos *et al.* 2011: 156). Surveys also provide numerical descriptions of trends, attitudes, or opinions of the population (Burns and Grove 2009: 245; Creswell 2009: 12; Punch 2005 cited in de Vos *et al.* 2011: 156). This lent for the choice of survey as a data collection strategy.

A quantitative, non-experimental, descriptive design was used to investigate the roles of registered nurses and psychiatric nurses at in-patient psychiatric facilities in KwaZulu-Natal. The study embraced the following two sequential phases:

Phase One focused on the collection and analysis of quantitative data utilising survey research. This phase of the study was aligned to the research aim and the first three objectives of the study:

- To explore which mental health problems are most commonly seen amongst psychiatric patients at these facilities.
- To investigate the challenges faced by psychiatric nurses when caring for psychiatric patients.
- To investigate what specialized knowledge and skills are required when nursing such patients.

Phase Two focused on a qualitative analysis of the curricula of the current psychiatric programmes in nursing. It was linked to objectives three and four of the study, namely:

- To investigate what specialized knowledge and skills are required when nursing such patients.

- To investigate whether their education and training prepared them adequately to deal with psychiatric patients and suggest guidelines to strengthen nursing education.

3.3 RESEARCH SETTING

The study was conducted at four Health Districts in KwaZulu-Natal and utilized six facilities in these Health Districts. The facilities are Town Hill Hospital, Fort Napier Hospital, Umgeni Hospital, which is located in the UMgungundlovu Health District, Ekuhlengeni Hospital, which is located in the EThekwini Health District, Madadeni Hospital, which is located in the Amajuba Health District and UMzimkhulu Hospital, which is in the Sisonke Health District. A survey of the consenting registered nurses and psychiatric nurses (n=436) was undertaken.

3.4 SAMPLE AND POPULATION

A population can be described as all the participants that are included in the study that meet the designated criteria and have similar characteristics (Polit and Hungler 1991: 223; Burns and Grove 2009: 42; LoBiondo-Wood and Haber 2010: 221; Polit and Beck 2012: 273). The present study utilized the population of registered nurses and psychiatric nurses at the six in-patient psychiatric facilities in KwaZulu-Natal for data collection. A census was therefore utilized in this study, as the entire population (n=436) was sampled (Polit and Beck 2012: 264). A statistician guided this process.

3.4.1 Sampling strategy

There was no sampling strategy, as the sample and population were one and the same. Telephonic contact with the nursing service managers and personal assistants at these facilities revealed that there are 436 registered nurses and psychiatric nurses employed at these facilities. A total of 436 questionnaires were distributed and 396 questionnaires were returned, yielding a response rate of 91%.

3.4.2 Inclusion and exclusion criteria

Eligibility or inclusion criteria are the stipulated attributes of the target population viewed as essential by the researcher for qualification of inclusion in the study (Burns and Grove 2009: 345; Polit and Beck 2012: 274). Exclusion criteria describe the specific characteristics which eliminated the participants from the study (Burns and Grove 2009: 345; Polit and Beck 2012: 274). The researcher utilized the following inclusion and exclusion criteria for this study.

Inclusion criteria

- Male and female consenting registered nurses and psychiatric nurses in KwaZulu-Natal, who were practising at the following Health Districts: UMgungundlovu, EThekwini, Amajuba, and Sisonke.
- Registered nurses and psychiatric nurses who were caring for psychiatric patients at these facilities.
- Registered nurses and psychiatric nurses working in the public sector.

Exclusion criteria

- All non-consenting participants.
- Registered nurses and psychiatric nurses working in the private sector.

Once the research sample was identified the data collection tool was selected.

3.5 DATA COLLECTION

3.5.1 The data collection instrument

Documents containing a collection of questions and statements are referred to as questionnaires (Babbie and Mouton 2001 cited in de Vos *et al*. 2011: 186). A self-report questionnaire requiring respondents to indicate their choices in response to the questions asked was used in this study (Manamela *et al.* 2003: 90). Questionnaires are usually used to gather data from individuals about their knowledge, attitudes and opinions related to the topic being studied in surveys

(Burns and Grove 2009: 406; LoBiondo-Wood and Haber 2010: 274). Questionnaires are composed of items which measure concepts or variables such as age, marital status and years of education (LoBiondo-Wood and Haber 2010: 275).

Six types of questionnaires were identified, mailed, telephonic, hand-delivered, group-administered, electronic and self-administered questionnaires (de Vos *et al.* 2011: 186). This study utilized self-administered questionnaires which were handed to consenting participants for completion. Data can be collected using existing measuring instruments or the researcher constructs a tool for the study (Mouton 2001: 100). The researcher chose to utilise existing instruments. The questionnaire used in this study was based on validated questionnaires from other studies (Jones and Lowe 2003: 8; Lesinskiene, Jegorova and Ranceva 2007: 761). Permission to adapt and utilize segments of the questionnaires developed by Jones and Lowe (2003: 8); Lesinskiene, Jegorova and Ranceva (2007: 761) was sought and obtained (Appendix 2).

Jones and Lowe (2003: 8) explained that there was no specific reliability testing conducted on the instrument. Lesinskiene, Jegorova and Ranceva (2007: 761) stated that the study was designed as a pilot study of a questionnaire developed by these researchers, analysing the working conditions of psychiatric nurses at in-patient facilities.

The instrument used in the present study was a self-administered questionnaire (Appendix 1). Questionnaires were handed to the respondents, who completed them on their own. The researcher's details were available if the respondents had queries. The questionnaire used in this study consisted of six sections, which were designed around the research aim and objectives. The questionnaire was made up of the following subsections:

- Section one of the questionnaires focused on aspects such as demographic data and included other personal and professional background information. This section had nine questions, most of which were closed-ended questions. Closed-ended questions provided a set of options from which respondents may choose one or more items (Maree and Pietersen 2007 cited in de Vos *et al*. 2011: 198; Polit and Beck 2012: 297). The open-

ended questions used in this study offered respondents the opportunity to write a response in their own words (de Vos *et al.* 2011: 196; Polit and Beck 2012: 297).

- Section two provided definitions of a psychiatric nurse and included questions on areas of nurses' levels of comfort and mental health and behavioural problems encountered. All twenty one questions in this section were Likert scale questions. According to Brink (2002: 160) "a Likert scale is an example of a summated rating scale which is frequently used to test attitudes and feelings". A five-point Likert scale was used to rate responses in this study. Respondents had five choices: strongly disagree, disagree, uncertain, agree and strongly agree. Other options offered were: never, rarely, often, very often and all the time.
- Section three consisted of twelve statements on a Likert scale related to feelings towards the challenges faced in practice.
- Section four focused on nurses' preparedness to care for psychiatric patients. This section had six Likert scale questions and a matrix question. The matrix question allowed for a variety of interrelated questions to be answered in one question (de Vos *et al*. 2011: 201).
- Section five investigated the specific knowledge and skills psychiatric nurses require when caring for psychiatric patients. This section was divided into four sub-sections, consisting of a Likert Scale, with an open-ended question and two multiple choice questions. Open-ended questions provided answers to which respondents stated what is of importance to them (Neuman 2006 cited in de Vos *et al*. 2011: 196). Multiple choice questions provided a choice of three or more options for respondents when answering questionnaires (de Vos *et al.* 2011: 199; Polit and Beck 2012: 298).
- Section six focused on suggestions for guidelines to strengthen nursing education. It contained both multiple choices and an open-ended question.

Polit and Beck (2012: 307) identified four important considerations when wording questionnaires:

- Questionnaires should be unambiguous, clear and precise.

- Wording in the questionnaire must be understood by the respondent and be at the appropriate academic level of the respondent, to ensure adequate provision of information.
- The wording in questionnaires should avoid respondent biases.
- The researcher should display consideration towards respondents' needs in areas such as politeness and sensitivity, especially during collection of personal data (Polit and Beck 2012: 307).

The researcher adopted these guidelines when designing the questionnaire. Once the questionnaire for this study was designed, a pilot test was conducted.

3.5.2 Pilot study

Pilot studies are procedures for testing and validating an instrument prior to data collection, by administering it to a small group who are excluded from the study (Barker 2003 cited in de Vos *et al.* 2011: 237). Mitchell and Jolley 2001 cited in de Vos *et al.* (2011: 237) added that a pilot study "helps the researcher to fine-tune and debug the process". Burns and Grove (2009: 44) further stated that the pilot study can be used to refine the research instrument.

3.5.3 Validity and reliability

Validity and reliability of instruments are two important criteria by which an instruments' quality is evaluated (Guyatt 1993 cited in Manamela *et al*. 2003: 90). Reliability of an instrument refers to the consistency, stability, accuracy and dependability of the instrument each time it is administered to participants (Polit and Hungler 1991: 295; Brink 2002: 124). An instrument is reliable when it measures the same variable more than once and produces identical or near identical results each time it is applied (Salkind 2006 cited in de Vos *et al.* 2011: 177). Several methods are used to establish the reliability of an instrument. The most widely used reliability measure is Cronbach's Alpha coefficient. The values range between 0 and 1, and the figures closer to 1, e.g. 0.8 to 0.9, would indicate a highly reliable scale (de Vos *et al.* 2011: 177).

Burns and Grove (2009: 380); Polit and Beck (2012: 336) agreed that validity is the extent to which the instrument actually measures the concepts it is intended to measure. Questions included in the instrument were designed in alignment with the research aims and objectives.

Content validity refers to the degree to which an instrument measures what it is supposed to measure and how accurately the questions asked produced the required information (Polit and Hungler 1991: 300; LoBiondo-Wood and Haber 2010: 288; Polit and Beck 2012: 336). Given that sections of this questionnaire were tested for validity and reliability, it was still given to a local group of experts, five nurse educators and practitioners, as part of the pilot process. It was reviewed further and refined by the expert group to assess the content validity of the instrument (de Vos *et al*. 2011: 238; Polit and Beck 2012: 357). de Vos *et al.* (2011: 239) said that the input of experts was especially important in caring professions, such as nursing, as they could provide clarity in areas of speciality, as well as confirm uncertainties in psychiatric nursing. Following the testing, the panel of experts' opinions were utilised to inform decisions made related to the addition and deletion of items in the questionnaire (de Vos *et al*. 2011: 239; Polit and Beck 2012: 357). Queries, problems and recommendations based on the outcome of opinions of the expert group enabled the researcher to modify the questionnaire. The questionnaires and the participants of the expert group were excluded from the study. This group reinforced the previous testing for validity and reliability of previous questionnaires (Jones and Lowe 2003: 8; Lesinskiene, Jegorova and Ranceva 2007: 759).

Face validity refers to what an instrument seems to measure. The appearance of an instrument is not considered strong evidence for validity; however, its appearance seems to be relevant to the participants completing the questionnaire (Gravetter and Forzano 2003 cited in de Vos *et al.* 2011: 173). Data collection process began thereafter.

3.5.4 Data collection procedure

LoBiondo-Wood and Haber (2010: 269) described data collection as a systematic, uniform and consistent process of gathering information about respondents. Data collection is an objective process that avoids researcher biases which could influence the ideas, opinions or beliefs of respondents.

The data collection process commenced once written ethical approval was granted by the Durban University of Technology Institutional Research and Ethics Committee (Appendix 4). Following approval, the researcher obtained written permission from the facilities included in the study and the Department of Health, KwaZulu-Natal, Research and Knowledge Management. The data collection process commenced in June 2013 and was completed in the latter part of July 2013.

A meeting was arranged with the Nursing Service Managers to discuss the purpose and value of the study. At this meeting the procedure for data collection was explained, dates and times for the delivery and collection of the questionnaires was negotiated and the inclusion and exclusion criteria explained. The purpose, nature, benefits and risks of the study were explained to the Nursing Service Managers by the researcher. The consenting participants completed a letter of information supplied by the researcher (Appendix 3). The researcher then answered the questions and concerns raised by the participants. The questionnaires were delivered to the Nursing Service Managers and the Operational Managers personally, with two clearly labelled sealed boxes. The latter was stored in a locked venue, where participants were able to at times drop off completed questionnaires. The data collection process was overseen by the researcher. The researcher collected the sealed drop off boxes a month later, on the agreed-upon date. All questionnaires returned were prepared for data capturing and analysis.

3.5.5 Data preparation

Following the data collection process, the researcher personally collected the sealed boxes with completed questionnaires from the Nursing Service Managers.

Coding is a means of systematically rearranging the data into numerical form to facilitate data capturing (Burns and Grove 2009: 432; de Vos *et al*. 2011: 252). Each questionnaire was numbered by the researcher. The data was prepared for analysis by checking for errors and completeness (Sarantakos 2005 cited in de Vos *et al*. 2011: 252). The coding process was guided by a statistician (Appendix 8).

3.5.6 Data entry

The data was prepared in a grid format to facilitate data entry on the computer, using software program SPSS statistical version 20.0, for data analysis. The format of choice was a spreadsheet which consisted of columns containing variables or question responses (de Vos *et al*. 2011: 253).

3.6 QUANTITATIVE DATA ANALYSIS

Quantitative data analysis has been referred to as the process of converting data to numerical form, using statistical techniques. The data for this study was reduced and analysed with the assistance of a professional statistician, using the statistical software SPSS statistical version 20.0. Mouton (2001: 108) explained that the aim of data analysis was to create an understanding of the elements of the data by identifying relationships between the concepts being studied. He added that patterns, commonalities, as well as themes, are identified in the data during analysis (Mouton 2001: 109). In this study, in-depth statistical analysis regarding the years of experience, common clinical and behavioural challenges encountered in practice, education and training preparedness were the areas analysed. This was correlated with the participants' preparedness to deal with psychiatric patients. The statistical approach of this study incorporated descriptive and inferential statistics.

3.6.1 Descriptive statistical analysis

Descriptive statistics allows the researcher to organize and summarize data, provides meaning and insight to data and permits the examination of data from various angles (Burns and Grove 2009: 470). Univariate and bivariate analysis, which is the most suitable for descriptive statistics, was applied in this study. Univariate analysis is concerned with measurement of central tendency and dispersion. The most appropriate measure of central tendency for interval data is the mean and the most suitable measure of dispersion for interval data is the standard deviation. Bivariate analysis measures two variables at a time (Lind, Marchal and Mason 2004: 6). Descriptive statistics is valuable, since it summarises results for investigations and allows for further constructive research as a result of detailed analysis. Numerical data is described by investigating the distribution of scores on each variable and determining whether the scores on different variables form a relationship to each other (Lind, Marchal and Mason 2004: 6). Data gathered is presented in tabular or graphic form (de Vos *et al.* 2011: 254). In this study, descriptive statistics using frequency and cross-tabulation tables, along with various types of graphs such as pie and bar charts were used.

3.6.2 Inferential statistical analysis

Inferential statistics investigates whether relationships observed in a given sample are likely to occur in a population (Polit and Hungler 1991: 459). Inferential statistics, using Pearson's and Spearman's correlations at a significance level of 0.05, were utilised. Pearson's correlation presents an indication of the magnitude and the direction of the relationship between two variables. The closer the values are to 1, the greater the relationship; whilst values closer to 0 indicate a weaker relationship (Lind, Marchal and Mason 2004: 457). The researcher is interested in investigating the roles, functions and activities of registered nurses and psychiatric nurses at in-patient psychiatric facilities. Spearman's rank-order correlation was also applied to data. It is a correlation coefficient which indicates the magnitude of the relationship between variables measured on an ordinal scale (Polit and Beck 2012: 743).

3.6.3 Chi-square test

Chi-square testing was also conducted, using nominal and ordinal data at a usual level of significance of 0.05 or 0.01. The chi-square test of independence assesses whether the two variables being analysed are independent or related. Chi-square tests for variations in frequencies of observed data and identifies the possible frequencies that could occur if the categories were independent of each other (Burns and Grove 2009: 500).

3.6.4 Factor analysis

Factor analysis was also used in the study to identify variables or factors that provide explanation for the pattern of correlations within a set of observed variables. Factor analysis is used in data reduction to identify a small number of factors that explain most of the variance that is observed in a much larger number of manifest variables. Factor analysis is also used to generate hypotheses about interrelationships among variables and detect variables for future analysis (Polit and Beck 2012: 341).

3.7 PRESENTATION OF QUANTITATIVE DATA

Quantitative findings were presented in the form of tables, graphs and bar charts. The types of tables, cross tabulations and figures used in the study will be briefly described below.

- **Tables**

  Tables are used to present a vast amount of information concisely and clearly and demonstrate relationships between variables, identify changes in information and reduce the amount of discussion in the text (Burns and Grove 2009: 570).
- **Contingency or cross-tabulations**

  Contingency tables permit the visual display of the relationship between sets of nominal data (Brink 2002: 189). In this study the relationships between gender and current workplace were investigated. Data generated

from observations made on two different associated categorical variables (bivariate) were summarised by using a table or contingency tables (Willemse 2009: 28).

- **Graphs**

  In this study bar graphs were used to display discrete data. The bars presented data horizontally and vertically. Measurement of data was possible at various levels of complexity. All bar graphs used in this study were of the same width and length that were consistent with the frequency (Willemse 2009: 29).

  In this study, quantitative findings strengthened the qualitative phase which will be presented below.

PHASE TWO

3.8 QUALITATIVE RESEARCH METHODOLOGY

This method follows a flexible, circular pattern, whereby the researcher continually examines and interprets the data (Polit and Beck 2012: 60). Qualitative researchers “almost develop their own design as they go along”, making use of strategies to guide the study. The qualitative researcher focuses on understanding, rather than explanations of the information (de Vos *et al.* 2011: 308). Qualitative research designs involve exploring and understanding meanings to a specific problem (de Vos *et al.* 2011: 64).

The steps involved in qualitative research include a review of the literature, development of a framework and setting research questions (Burns and Grove 2009: 23). One way of collecting qualitative data is from documents (Creswell 2009: 181). The data collection and analysis process in qualitative research occur concurrently. The researcher interprets the meaning of the gathered data by interpreting words. In qualitative analysis, the interpretation and reasoning flows from concreteness to abstraction. This reasoning process directs the organization, reduction and grouping of the findings (Burns and Grove 2009: 23). The qualitative approach in this study is document analysis.

3.8.1 Document analysis

Ritchie and Lewis 2003 cited in de Vos *et al.* (2011: 377) defined document analysis as the study of current documents aimed at gaining greater understanding of the content of the documents. Content analysis is the classification of words from texts into categories, in order of importance (Burns and Grove 2009: 528). Jupp 2006 cited in de Vos *et al.* (2011: 380) described content analysis of documents as a systematic and enumerative approach to quantify elements such as words or images. Creswell (2009: 184) added that the data undergoes a representation and formulation of an interpretation of the meaning of the data. This phase will utilize thematic analysis, which involves measuring the frequency, order and intensity of words and phrases utilized in the psychiatric nursing curricula (Burns and Grove 2009: 528). The researcher will attend to the themes that will arise and the patterning of the themes which emerge from content analysis of the curricula and the responses of participants from the survey (Polit and Beck 2012: 562).

The curricula of current psychiatric programmes in nursing, which is the Diploma for Registration as a Psychiatric Nurse and the programme leading to Registration as a Nurse (General, Psychiatric and Community) and Midwife, was secured and qualitatively analysed in the public sector (South African Nursing Council SANC 1995). The curriculum was developed by the KwaZulu-Natal College of Nursing (KZNCN) in 2005, in accordance with the guidelines and directives of the SANC (1985). Based on the findings made in the survey the researcher explored the areas of current education needing to be strengthened, to ensure educational preparedness to work with this specialized group. Areas in the curriculum identified from the survey as needing to be strengthened were submitted as recommendations for review of the curriculum, which is subject to change from 2014 onwards. The curricula was analysed, similarities identified and responses grouped into categories or themes (Lo Biondo-Wood and Haber 2010: 128). Information obtained from the quantitative phase helped to suggest and strengthen guidelines for education in this area following the content analysis of the psychiatric nursing curricula.

Recommendations for review of the curricula will be presented and suggested at KZNCN Subject Sub-committee meetings. These recommendations will be forwarded to the KZNCN Principals' meetings, KZNCN College Council, and for approval at the Senate. The researcher, who is a KZNCN subject sub-committee member, will submit the findings of the study as recommendations for psychiatric nursing education as input towards the review of the curriculum. The findings from this study are further intended to assist the SANC, at their discretion, with a review of the curricula for the one year Diploma for Registration as a Psychiatric Nurse.

3.9 ETHICAL CONSIDERATIONS

Ethics is defined as a system of moral values related to the extent to which the research process maintains the professional, legal and social obligations of the study participants (Polit and Beck 2012: 727). The proposal was reviewed by the Departmental Research Committee, Faculty Research Committee and Institutional Research and Ethics Committees of the Durban University of Technology. The latter committee approved the proposal and the study was granted full ethical clearance (reference number: REC.73/2012, ethical clearance number IREC 026/13). The researcher began data collection in June 2013, after complying with the requirements set out by the Institutional Research and Ethics Committee of the Durban University of Technology.

The Institutional Research and Ethics Committee check-list of the Durban University of Technology was completed. Consenting participants completed a letter of information and consent (Appendix 3).

Appendix 3 included the following information:

- Identification of the researcher, the sponsoring institution, selection of participants, the title and purpose of the study.
- Respondents were informed of the procedure followed during data collection.
- Benefits and risks of participation for the respondents.
- Participation was voluntary.

- Respondents were informed of their rights, especially the right to withdraw from the study, without consequences.
- There would be no remuneration for the respondents or the researcher.
- There would be no costs incurred for the consenting respondents.
- Confidentiality and anonymity of respondents would be maintained at all times.
- Contact details were furnished of persons to direct queries relevant to the study.

All attempts to uphold research ethics were undertaken. Permission was obtained from the Department of Health KwaZulu-Natal Research and Knowledge Management, the Chief Executive Officers and Nursing Service Managers and Operational Managers of the facilities (Appendix 5.1 to 5.6). All data was kept in a lock-up cabinet throughout the study, with researcher access. Data will be retained for a period of 15 years, thereafter it will be shredded.

3.10 CONCLUSION

This chapter outlined the research design, research setting, the population and sample used in the study. The data collection instrument, data collection and analysis of data, using the statistical software tool (SPSS 20.0), was presented. The statistical tests conducted on the data were Cronbach's alpha, Chi-square test and the correlation tests, Pearson's and Spearman's tests. Phase two of the study, a qualitative documentary analysis, was presented. In the next chapter, quantitative and qualitative data will be presented.

CHAPTER 4

PRESENTATION OF FINDINGS

4.1 INTRODUCTION

This chapter presents the data obtained from the survey conducted in this study and from the qualitative curricula content analysis. A questionnaire was the primary tool that was used to collect data and was distributed to registered nurses and psychiatric nurses at the six psychiatric in-patient facilities in KwaZulu-Natal. These hospitals are located in the UMgungundlovu Health District, EThekwini Health District, Amajuba Health District and Sisonke Health District. The data collected was analysed with SPSS statistical version 20.0. Descriptive statistics in the form of cross-tabulations, graphs and other figures for the data collected will be presented. Inferential techniques include the use of correlations and chi-square test values, which are interpreted using the p-values.

4.2 SAMPLE AND POPULATION

A census was utilised in this study. The entire population (n=436) was sampled. The population of registered nurses and psychiatric nurses at the facilities is indicated in Table 1. A total of 436 questionnaires were distributed, 396 were returned and completed, reflecting a response rate of 91%. This was an excellent response rate and was possible due to the fact that the researcher allowed participants a month to complete them after the initial drop-off date.

Table 1 reflects the distribution of respondents across the six psychiatric facilities in KwaZulu-Natal. As can be seen, 35% (n=138) participated from Town Hill Hospital; 30% (n=118) participated from Fort Napier Hospital; 12% (n=47) participated from Madadeni Hospital; 9 %(n=36) participated from UMzimkhulu Hospital; 7% (n=29) participated from Ekuhlengeni Hospital and 7% (n=28) of participants were from Umgeni Hospital.

Table 1: Number of registered nurses and psychiatric nurses participating from the six in-patient psychiatric facilities

	Facility / Hospital	**Frequency**	**Percentage of the total population**
1.	Town Hill Hospital	138	35%
2.	Fort Napier Hospital	118	30%
3.	Madadeni Hospital	47	12%
4.	UMzimkhulu Hospital	36	9.0%
5.	Ekuhlengeni Hospital	29	7%
6.	Umgeni Hospital	28	7%
	Total	396	100%

4.3 DATA ANALYSIS

Nominal and ordinal levels of measurement were used to analyse gathered data. A nominal level of measurement has been described as categorising data by age, gender or “yes or no” scales (de Vos *et al.* 2011:178). An ordinal scale or level of measurement classifies data and places them in rank order, from highest to lowest, e.g. a rating scale from five to one, commencing with strongly agree to strongly disagree (de Vos *et al*. 2011: 178; Burns and Grove 2009: 375).

4.4 THE RESEARCH INSTRUMENT

The questionnaire consisted of 110 items, with a level of measurement at a nominal or an ordinal level.

PHASE ONE

SECTION 1

This section summarises the demographic characteristics of the respondents. It indicates information on gender, age and type of training programme, whether participants training were part-time or full-time, their highest qualifications, job title, current workplace and the number of years they have worked at psychiatric in-patient facilities.

4.5 DEMOGRAPHIC DATA

4.5.1 Gender

The gender sample distribution for females was 65.9% (n=261) and males were 34.1% (n=135). The ratio of females to males was approximately 2:1. This reflects the predominance of females in the nursing profession. However, the slightly larger number of males may be due to the fact that psychiatric nursing environments, in comparison to general hospital settings is an environment where staff is potentially at higher risk of harm.

4.5.2 Age group

Table 2 below indicates that 35.9% (n=142) of respondents were in the age category of 30 to 39 years. Twenty nine percent (n=115) of respondents were in the age group 40 to 49; 16.9% (n=67) were between 18 and 29 years, whilst 14.9% (n=59) were in the age category 50 to 59 years. Only 3.3% (n=13) of respondents indicated they were 60 years and above. It is possible that younger staff prefer to work in these high-risk facilities, as opposed to older staff.

Table 2: Age group

Age grouping	Frequency	Percentage
18 – 29	67	16.9%
30 – 39	142	35.9%
40 – 49	115	29.0%
50 – 59	59	14.9%
60 years and above	13	3.3%
Total	396	100.0%

4.5.3 Age and gender distribution

About sixty four percent (n=91) of the females were in the age range 30 to 39, whilst males in this age category were 35.9% (n=51). More than 60% (n=70) of female respondents were in the age group 40 to 49 years, however only 39.1% of (n=45) males were in this age group. The age-gender distribution for respondents

between 18 and 29 were 61.2% (n=41) females and 38.8% (n=26) males. Female respondents aged 50 to 59 years were 81.4% (n=48) and males were 18.6% (n=11). Within the age category of 60 years and above, females were represented by 4.2% (n=11), whilst males were 1.5% (n=2) of the sample.

4.5.4 Training programme

Table 3 reflects that nearly half (48.4%; n=192) of the sample had done a four year diploma. Almost 30% (n=118) of respondents completed a one year Psychiatric Diploma. More than 15% (n=60) of respondents completed the one year Psychiatric Diploma and later completed the Advanced Psychiatric Diploma. The following psychiatric nurse training programmes were reported as being completed: Advanced Psychiatric Nursing (2.8%; n=11), a three year Psychiatric Diploma (2.0%; n=8), an 18-month Psychiatric Nursing Diploma (1.3%; n=5), whilst 0.3% (n=1) of respondents completed the Advanced Psychiatric Diploma and an 18-month Psychiatric Nursing Diploma. Only 0.3% (n=1) of respondents indicated that they had not completed any psychiatric training programme.

Table 3: Training programme

Type of training programme	Frequency	Percentage
4-Year Diploma	192	48.4%
1-Year Psychiatric Diploma	118	29.8%
Advanced Diploma and 1-Year Psychiatric Diploma	60	15.1%
Advanced Psychiatric Diploma	11	2.8%
3-Year Psychiatric Diploma	8	2.0%
18-Month Psychiatric Diploma	5	1.3%
Advanced Psychiatric and 18-Month Psychiatric Diploma	1	0.3%
None	1	0.3%
Total	396	100%

4.5.5 Full-time or part time studies

Respondents were also asked to indicate whether the programme they attended was full-time or part-time. More than 80% (n=326) of respondents had done their studies on a full-time basis (see Table 4). Almost 15% (n=59) of respondents completed full-time and part-time studies, whilst only 2.5% (n=10) of respondents stated that they completed their studies part-time.

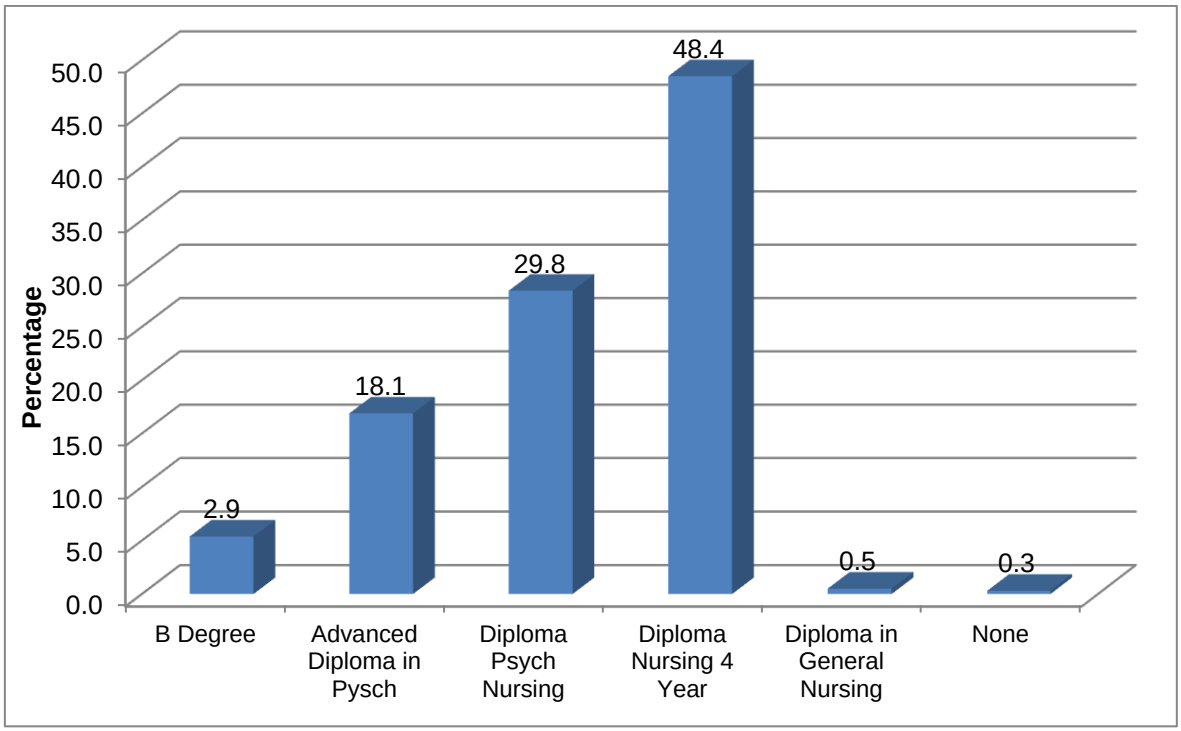
Table 4: Full-time or part-time training programme

Training programme	Full-time or part time studies				Total
	Full-time	Part-time	None	Full-time and part-time	
Advanced Psychiatric Diploma	1.0%(4)	1.5%(6)	0%(0)	0.3%(1)	2.8%(11)
1 Year Psychiatric diploma	29.3%(116)	0.5%(2)	0.0%(0)	0.0%(0)	29.8%(118)
4 Year Comprehensive Diploma	48.4%(192)	0%(0)	0%(0)	0%(0)	48.4%(192)
18 Month Psychiatric Diploma	0.8%(3)	0.5%(2)	0%(0)	0%(0)	1.3%(5)
3 Year Psychiatric Diploma	2.0%(8)	0%(0)	0%(0)	0%(0)	2.0%(8)
Advanced Psychiatric and 1year Psychiatric diploma	0.8%(3)	0%(0)	0%(0)	14.4%(57)	15.1%(60)
Advanced Psychiatric and 18 Month Psychiatric diploma	0%(0)	0%(0)	0%(0)	0.3%(1)	0.3%(1)
None	0.0%	0.0%	0.3%(1)	0.0%	0.3%(1)
Total	326 82.3%	10 2.5%	1 0.3%	59 14.9%	396 100.0%

4.5.6 Participants' highest qualifications

As can be seen in Figure 1, 48.4 % (n=192) had a four year Comprehensive Nursing Diploma; 29.8% (n=118) completed a Psychiatric Diploma; 18.1% (n=72) have an Advanced Diploma in Psychiatric Nursing. Only 2.9% (n=11) of respondents completed the Bachelor's degree in Nursing, whilst 0.5 % (n=2) obtained a Diploma in General Nursing. Only one respondent obtained no qualification in psychiatric nursing.

Figure 1: Highest qualification



4.5.7 Job title in the nursing profession

A majority of the respondents 84.9% (n=333) were Registered Psychiatric Nurses; 13.5% (n=53) were Operational Managers, 0.8% (n=3) were Assistant Nursing Service Managers and 0.8% (n=3) were Nursing Service Managers,whilst 1.0% (n=4) of respondents omitted the job title.

4.5.8 Current workplace of sample

Almost half (45.2%; n=179) of the sample worked at chronic and forensic wards; 26% (n=103) worked in male and female acute wards and 15.4% (n=61)of respondents worked at male and female sub-acute or forensic wards. Approximately 2.5% (n=10) of respondents indicated male and female pre-discharge wards; 2% (n=8) worked at psychiatric outpatient departments and 2% (n=8) worked at child and adolescent units. Respondents working at the psychotherapy wards were 1.8% (n=7); nursing management was 1.5% (n=6) and male psychogeriatric or chronic wards were 1.3% (n=5). Only 0.5% (n=2) of respondents worked with intellectually challenged persons, whilst 0.5% (n=2) of respondents indicated the learner liaison departments. A small percentage (1.3%; n=5) of the data was missing.

4.5.9 Number of years working at psychiatric in-patient settings

The sample was also asked to indicate the number of years that they had worked at in-patient psychiatric facilities. As reflected in Table 5, 43.7% (n=173) of the sample have been working at in-patient psychiatric facilities for more than 10 years; about 25% (n=97) for 1 to 5 years and 21.4% (n=85) for a period of 6 to 10 years. Only 10.1% (n=40) of respondents had worked for less than a year. Respondents were also asked to indicate the number of years they had worked at health care settings. Findings reflect that 20.4% (n=81) of respondents had worked for 11 to 42 years, whilst 3.5% (n=14) had worked for 20 years.

Table 5: Years working in psychiatric in-patient settings

Years working in psychiatric facilities	Frequency	Percentage
< 1 year	40	10.1%
1-5 years	97	24.5%
6-10 years	85	21.4%
>10 years	173	43.7%
Total	395	99.7%
Missing data	1	0.3%
Total	396	100.0%

4.5.10 Choice of workplace

As reflected in Table 6, a majority (92.2%; n=365) of respondents indicated that they preferred working at mental health care facilities. Only a small portion (7.3%; n=29) of respondents indicated that it was not their choice to work at these facilities.

Table 6: Personal choice of mental health facility as their workplace

Choice of mental health facility as their workplace	**Frequency**	**Percentage**
Yes	365	92.2%
No	29	7.3%
Total	394	99.5%
Missing data	2	0.5%
Total	396	100.0%

The reasons given by those who said that it was not their choice to work at mental health facilities were:

- I was allocated to a mental health care facility.
- I applied for a promotional position.
- These facilities were closer to my home.
- There were no posts at General Hospitals.
- This was the first facility that replied to my application for a job.
- I wanted to learn more about psychiatric nursing.

It would therefore appear that most had worked at mental health facilities due to personal preferences.

SECTION 2

This section deals with data regarding whether nurses believed psychiatric nursing to be important in holistic practice, their levels of comfort in terms of working at these facilities and the clinical mental health and behavioural problems which psychiatric nurses encounter in practice.

4.6 HOLISTIC NURSING PRACTICE

4.6.1 Psychiatric nursing care and holistic nursing practice

Respondents' views regarding whether psychiatric nursing care is an important part of holistic nursing practice was assessed, using a Likert scale. This consisted of positively worded statements, e.g. "do you believe that psychiatric nursing is an important part of holistic nursing practice". A five-point Likert scale, ranging from 1=strongly disagree to 5=strongly agree, was used to measure participants' levels of agreement with this statement.

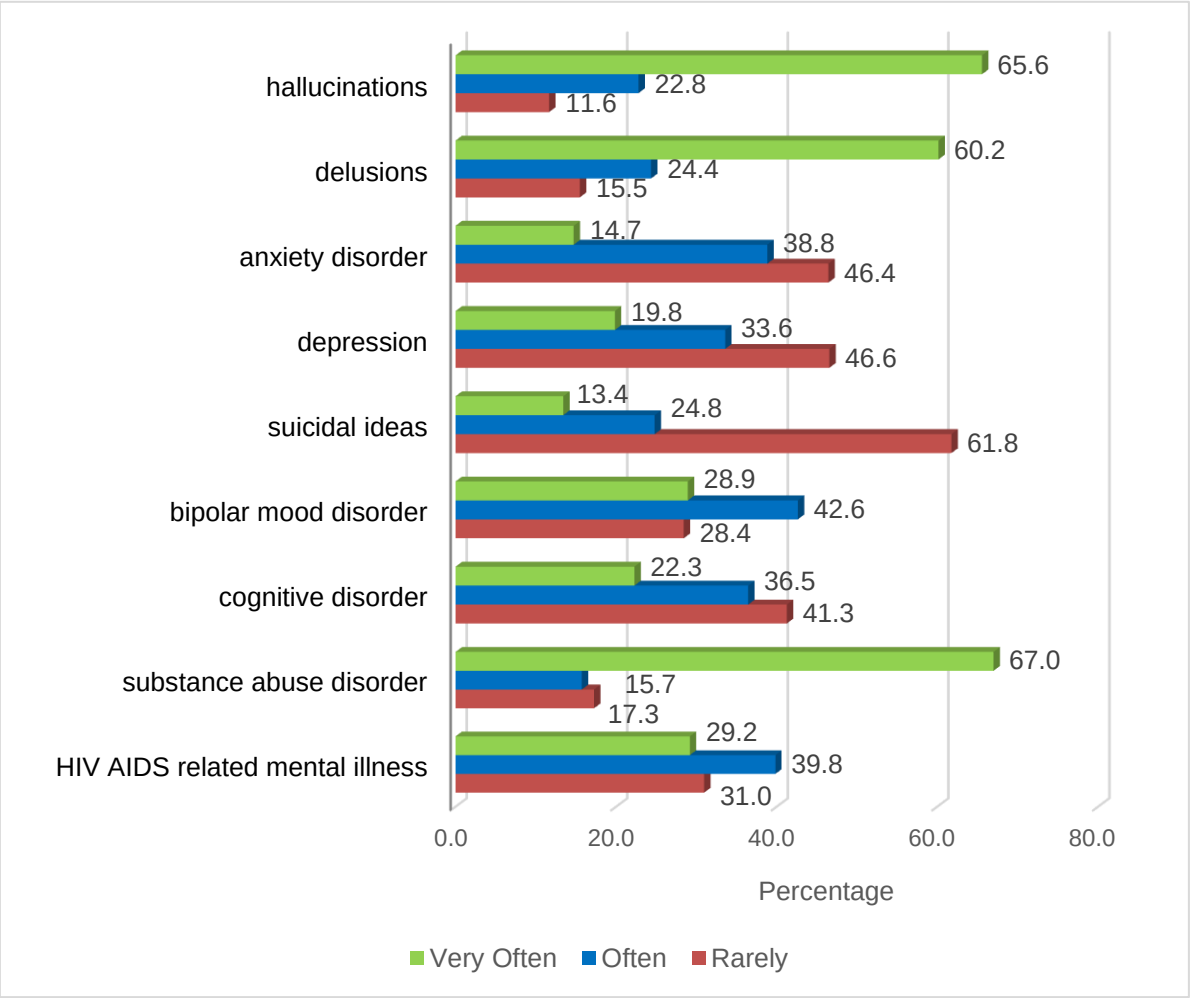
Almost all respondents (98.5%; n=390) agreed with the aforementioned statement. Only 1.0% (n=4) of the sample disagreed with this statement. A further 0.5% (n=2) of respondents stated that they were uncertain.

4.6.2 Common clinical mental health problems

Respondents were asked to rate the frequency of common clinical mental health problems they encountered in practice. The frequency with which clinical mental health problems were encountered is ranked from highest to lowest in Figure 2.

As reflected in Figure 2, respondents identified substance abuse disorders (67.0%), hallucinations (65.6%) and delusions (60.2%) as being the most frequent clinical and mental health problems encountered. Other clinical mental health problems, e.g. HIV and AIDS related mental illness (29.2%), bipolar mood disorder (28.9%), cognitive disorder (22.3%) and depression (19.8%), were reported less frequently by respondents. The conditions least frequently reported by respondents were anxiety disorders (14.7%). Suicidal ideation was 13.4%.

Figure 2: Common clinical mental health problems



4.6.3 Comfort levels in terms of working at mental health care settings

Table 7 reflects that 86.6% (n=343) of respondents reported that they felt comfortable working at mental health care settings, whilst only 4.3% (n=17) of respondents indicated that they were uncomfortable. A further 9.1% (n=36) felt uncertain about working at mental health care facilities.

Table 7: Levels of comfort with working in mental health care facilities

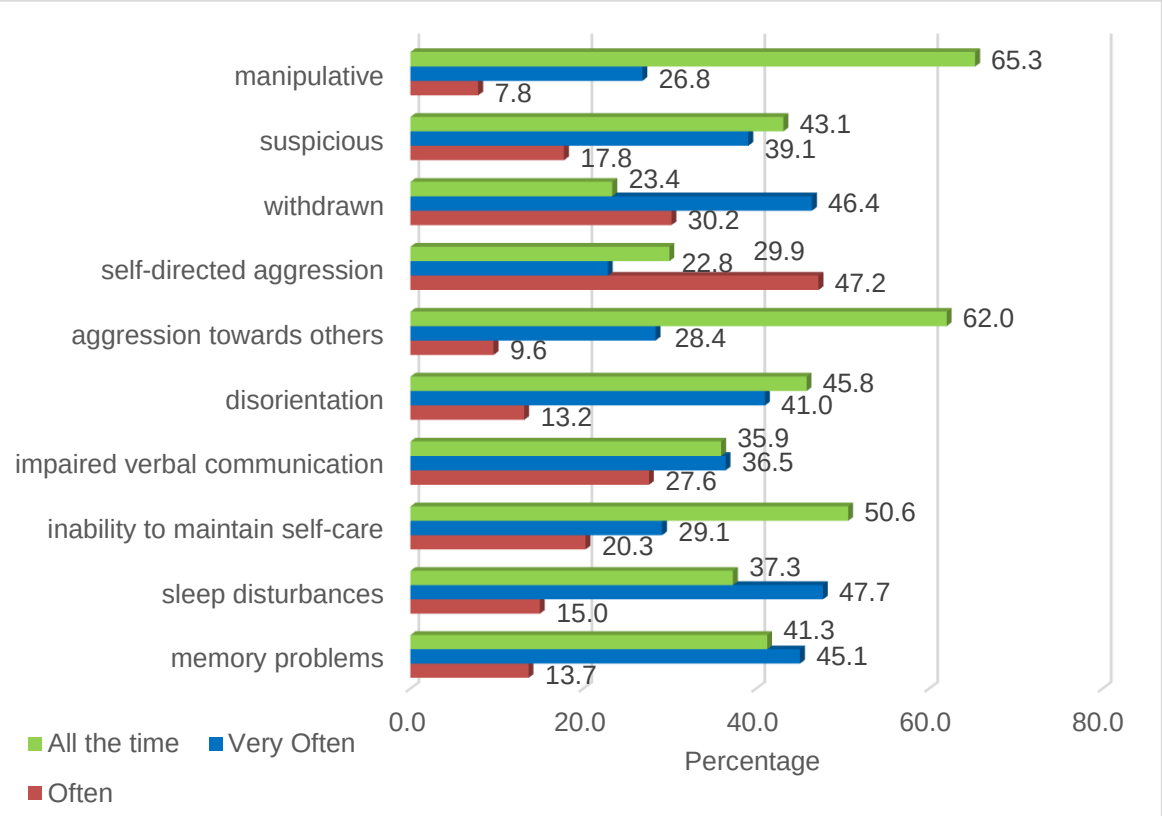
Levels of comfort with working at mental health care facilities	Frequency	Percentage
Comfortable	254	64.1%
Very comfortable	89	22.5%
Uncertain	36	9.1%
Uncomfortable	12	3.0%
Very uncomfortable	5	1.3%
Total	396	100.0%

4.6.4 Frequency distribution of behavioural patterns and problems encountered

Respondents were given a list of behavioural patterns and problems encountered in clinical practice and were asked to indicate which of these patients display most frequently. The frequency with which behavioural patterns and problems were displayed by patients was ranked from highest to lowest.

In Figure 3, for responses "all the time", "very often" and "often" an even pattern of distribution was found for the following behavioural patterns and problems: manipulative and suspicious behaviour, aggression towards others, disorientation and inability to maintain self-care. The most frequently encountered behavioural patterns and problems were manipulative behaviour (65.3%), aggression towards others (62.0%) and patients' inability to maintain self-care (50.6%). There were similarities found in the pattern of distribution for withdrawn behaviour (23.4%), sleep disturbances (37.3%) and memory problems (41.3%), across all ranges of responses.

Figure 3: Behavioural patterns and problems



SECTION 3

This section presents data in respect of the most common challenges faced by psychiatric nurses when dealing with mentally ill patients or mental health care users.

4.7 COMMON CHALLENGES FACED IN PSYCHIATRIC NURSING PRACTICE

Registered nurses and psychiatric nurses levels of agreement with the most common challenges faced in practice was established using a five-point Likert scale, ranging from 1=strongly disagree to 5=strongly agree. The scale included 11 positively and negatively worded statements. The responses were added to yield a single score (80.6%). Omitting the low level of agreement for the only

negative statement that was related to “negative patient perception” (6.6%; n=26) increased the average level of agreement to 87.3% for the statements in this section. A mean score of 87.3% suggests that challenges are encountered when caring for mental health care users.

Table 8 indicates high levels of agreement for the 10 statements in this section. Respondents agreed that “patients deny mental illness” (95.7%; n=379) and “exposure to patients unpredictable behaviour” (95.2%; n=377). Nurses are exposed to increased levels of aggression and violence (88.6%; n=351); facilities are inadequate (88.38%; n=350) and nurses encountered patients who refuse medication (88.35%; n=349). More than 75% (n=299) of respondents agreed that psychiatric nurses experience feelings of anger and frustration, whilst 73.1% (n=288) of respondents felt that psychiatric nurses face high levels of burnout and frustration.

Table 8: Levels of agreement and disagreement of challenges encountered

Statement	agree	uncertain	disagree
1.Patients deny mental illness	95.7%	2.0%	2.3%
2.Exposure to patients’ unpredictable behaviour	95.2%	2.3%	2.5%
3.Increased levels of aggression and violence	88.6%	2.8%	8.6%
4.Patients refuse medication (missing data:1)	88.3%	6.6%	5.1%
5.Inadequate facilities	88.3%	5.6%	6.1%
6.Lack of support and workplace dissatisfaction	87.6%	5.1%	7.3%
7.Stress or emotional exhaustion	87.0%	5.6%	7.4%
8.Staff shortage adds to emotional exhaustion and job satisfaction	86.1%	8.1%	5.8%
9.Feelings of anger and frustration (missing data: 2)	75.8%	10.2%	14.0%
10.Burnout and frustration (missing data: 2)	73.1%	17.5%	9.4%
11.Negative patient perception	6.6%	13.5%	79.9%

SECTION 4

In this section, data regarding preparedness to care for psychiatric patients will be discussed.

4.8 PREPAREDNESS TO CARE FOR PSYCHIATRIC PATIENTS

4.8.1 Levels of preparedness to care for psychiatric patients

A Likert-type scale was used to determine how often during training issues pertaining to care of patients with behavioural attitudes and problems were presented and discussed. A little more than half (53.9%) of respondents indicated that this was done very often; 32.7% of respondents stated that these aspects were discussed often; whilst 13.4% of respondents stated these areas were rarely presented or discussed.

4.8.2 Specific content related to psychiatric nursing care

Respondents were also asked to indicate “yes” or “no” when asked whether the issues that were addressed included specific content related to nursing mentally ill individuals.

Table 9 reflects that 91.9% (n=364) of the sample stated that content related to psychiatric patient care was presented, whilst 7.3% (n=29) reported that content was unrelated to mental health care nursing.

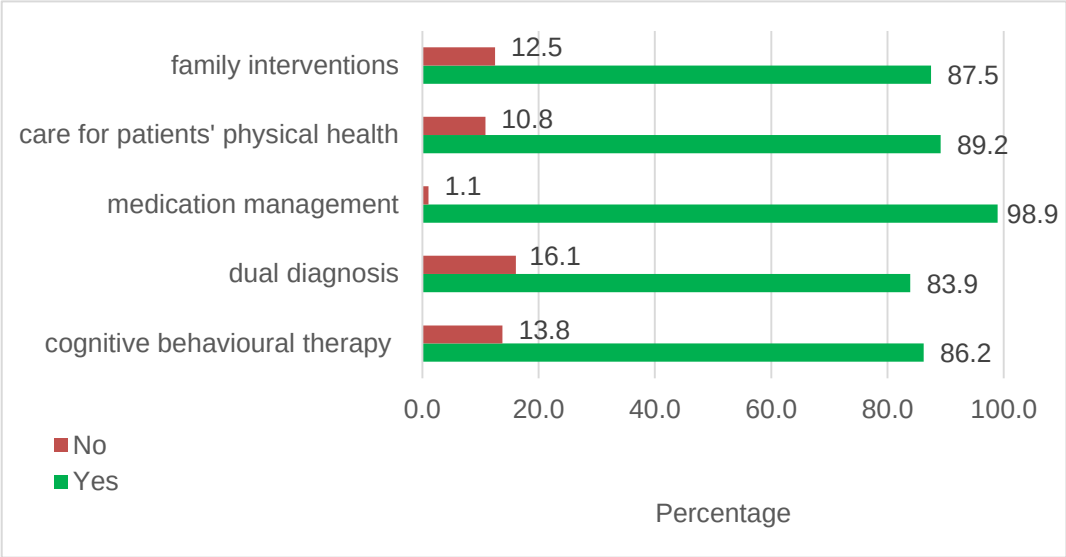
Table 9: Specific content related to nursing mentally ill individuals

Response	**Frequency**	**Percentage**
Yes	364	91.9%
No	29	7.3%
Missing data	3	0.8%
Total	396	100.0%

4.8.3 The focus areas in education

In this subsection, respondents were given a list of aspects related to educational focus and care for psychiatric patients. As presented in Figure 4, there is a proportionally even spread of agreement for “yes” responses. The areas in psychiatric nursing education frequently reported were medication management (98.9%); care for patients’ physical health (89.2%); family interventions (87.5%); cognitive behavioural therapy for patients (86.2%) and working with patients with dual diagnosis (83.9%).

Figure 4: Focus areas in education



4.8.4 Respondents' satisfaction levels with the amount of information presented for current qualification

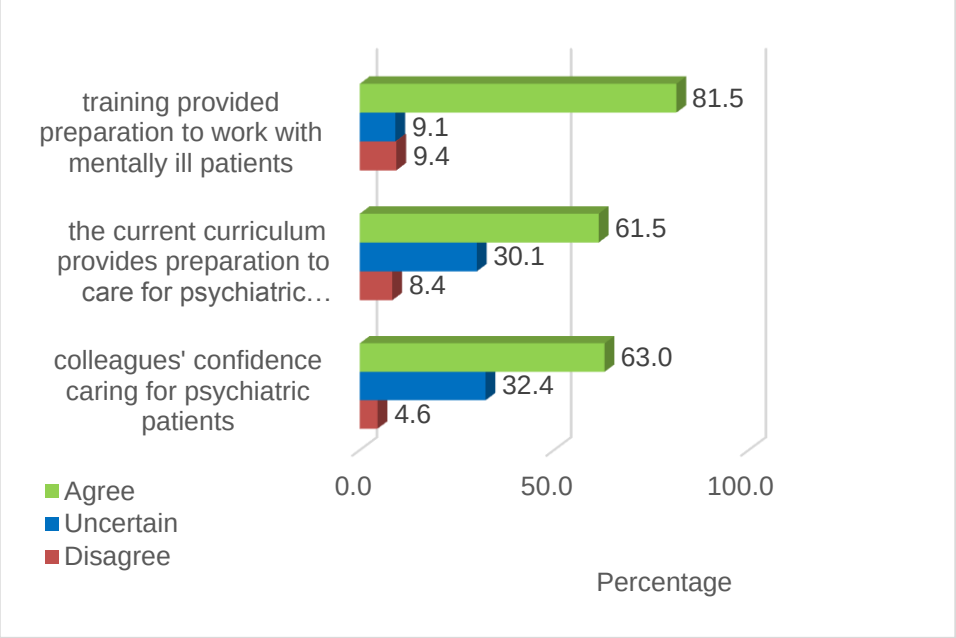
The sample was also asked to rate their satisfaction levels, from highest to lowest, with the amount of information presented during their training. Approximately 40.1% were highly satisfied with the amount of information presented, 45.5% of the sample said often satisfied, and the remaining 14.4% of respondents indicated being rarely satisfied with the amount of information presented during their training.

4.8.5 Preparation to care for mentally ill patients displaying behaviours and the confidence of colleagues

This subsection established respondents' levels of agreement with respect to the following: adequacy of preparation to care for psychiatric patients, aspects related to the handling of clinical problems or behaviours in the psychiatric nursing curricula and colleagues' confidence levels when caring for psychiatric patients.

Some responses on the scale (see Figure 5) reflect a high level of agreement (81.5%) for the statement "training provided preparation to work with mentally ill patients". Similar levels of agreement were found for "the current curriculum provides preparation" (61.5%) and the statement "do you feel your colleagues are confident caring for psychiatric patients" scored 63.0%.

Figure 5: Preparation of respondents to care for psychiatric patients and the confidence levels of their colleagues



4.8.6 Levels of confidence when caring for psychiatric patients

Respondents were asked to rate their levels of confidence when caring for psychiatric patients. Table 10 reflects that 93.4% (n=370) of respondents were confident in caring for psychiatric patients, while 5.3% (n=21) were uncertain of their confidence levels and a small portion (1.3%; n=5) expressed a lack of

confidence.

Table 10: Levels of confidence when caring for psychiatric patients

Levels of confidence when caring for psychiatric patients	Frequency	Percentage
Confident	253	63.9%
Very confident	117	29.5%
Uncertain	21	5.3%
Very unconfident	3	0.8%
Unconfident	2	0.5%
Total	396	100.0%

SECTION 5

This section investigates the specific knowledge and skills psychiatric nurses require when caring for psychiatric patients.

4.9 SPECIFIC KNOWLEGE AND SKILL REQUIRED IN PSYCHIATRIC NURSING PRACTICE

4.9.1 Levels of agreement for further training and development in psychiatric nursing practice

A Likert scale (see Table 11) was used to ascertain respondents' levels of agreement with a need for further training and development in psychiatric nursing and the management of psychiatric patients. Respondents were required to rank their level of agreement from 5=strongly agree to 1=strongly disagree. Approximately 71.1% of respondents said they felt a need for further training and development in nursing care and management of psychiatric patients, 15.7% of respondents were uncertain of their training needs, while 13.2% of respondents did not agree.

Table 11: Levels of agreement for further training and development in psychiatric nursing practice

Respondents' levels of agreement for further training and development in psychiatric nursing practice	Percentage

Agree	71.1%
Uncertain	15.7%
Disagree	13.2%
Total	100.0%

4.9.2 Training and development to enhance psychiatric nursing care and practice

Respondents were asked to indicate what specific knowledge and skill was required in order to enhance nursing care and practice.

Summary of the comments made by the respondents who indicated a need for further training

- In-service training and updates related to these areas: The Mental Health Care Act, Integration of Mental illness into Primary Health Care, Multidisciplinary Team Approach, psychosocial and substance abuse rehabilitation, family and community involvement, stigma and mental illness, current medication trends and medication compliance and the independent function of the Advanced Psychiatric Nurse.
- Information related to holistic nursing care in psychiatric settings.
- Further information on psychiatric conditions, delusions, suicidal conditions, substance-induced psychosis, personality disorders, eating disorders, bipolar mood disorders, HIV and AIDS and mental illness, dementia and mental illness and understanding mentally challenged persons.
- Further training on behaviour patterns and problems indicated, were manipulative and suspicious behaviour, management of aggression and violence and de-escalation.
- Skill development in these areas would enhance the care they provide, management and leadership skills, risk assessment and management, problem identification and management, crisis assessment and intervention, communication and counselling skills, stress management and cognitive behaviour modification and therapy.
- Traditional and cultural healing methods, mental illness and cultural issues related to patient care.

- Respondents indicated that an advanced psychiatric nursing qualification would improve the quality of services they render to psychiatric patients.

4.9.3 Training needs

Respondents were asked to indicate which aspects they required further training in. As reflected in Table 12, the percentage of cases column indicates the frequency in relation to the total number of respondents (n=396); 64.4% (n=253) suggested training in practical management of violence, aggression and de-escalation. Fifty five percent (n=216) stated that they would benefit from development and training related to the Mental Health Care Act no 17 of 2002. Training needs of the respondents varied from 42% to 49% for the following aspects: crisis assessment (48.3%), risk assessment (48.1%), crisis intervention (47.3%), mental health stigma (47.1%), physical safety of patients, self and others (44.0%) and stress management (42.5%). Other areas which ranged between 27% to 38% were psychological safety of patients, self and others (37.9%), medication management (32.8%), management of psychiatric illness (32.3%), communication and assertiveness skills (31.0%), problem management (27.0%) and problem identification (24.4%; n=96).

Table 12: Training needs

Training needs	**Frequency**	**Percentage of cases**
Practical management of violence, aggression and de-escalation	253	64.4%
Mental Health Care Act no 17 of 2002	216	55.0%
Crisis assessment	190	48.3%
Risk assessment	189	48.1%
Crisis intervention	186	47.3%
Mental health stigma	185	47.1%
Physical safety of patients, self and others	173	44.0%
Stress management	167	42.5%
Psychological safety of patients, self and others	149	37.9%
Medication management	129	32.8%
Management of psychiatric illnesses	127	32.3%

Communication and assertiveness skills	122	31.0%
Problem management	106	27.0%
Problem identification	96	24.4%
Total	2288	582.2%

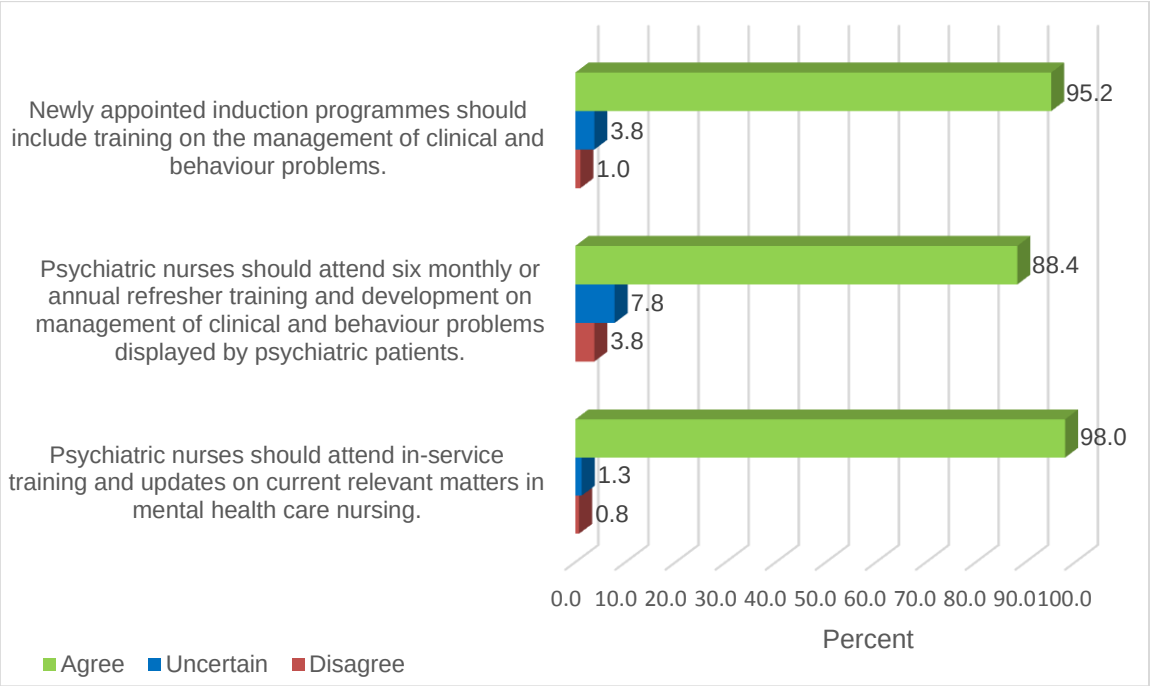
4.9.4 The type of training method and development programme

The favoured method for further training was institutional in-service training (58.0%; n=230); 45.9 % (n=182) selected 1 to 3 day courses, whilst 35.1% (n=139) preferred ward or departmental training. These values are percentage of cases and are relative to the total number of respondents (n=396).

4.9.5 Training programmes

This subsection presents data related to the training programmes psychiatric nurses believe would enhance psychiatric nursing care. A Likert scale using three statements (see Figure 6) reflected high levels of agreement for all three statements. More than 95% of the sample said that psychiatric nurses should attend in-service training and updates (97.9%; n=388) and 95.2% (n=377) said that induction programmes for newly qualified personnel should include training on the management of clinical and behavioural problems. Another 88.4% (n=350) of respondents felt that psychiatric nurses should attend six monthly or annual refresher training and development on the management of clinical and behaviour problems displayed by psychiatric patients.

Figure 6: Responses to the statements regarding training programmes



4.10 RELIABILITY STATISTICS

Reliability refers to the consistency and accuracy with which an instrument measures a variable more than once and yields the same results (de Vos *et al.* 2011: 177; Polit and Beck 2012: 331). Reliability of the questionnaire was measured using Cronbach's alpha coefficient, before other statistical tests were conducted.

4.10.1 Cronbach's alpha score

Reliability is computed by taking several measurements on the same subjects. The coefficient ranges between 0 and 1; figures closer to 1, e.g. 0.7 or 0.8, generally indicate a highly reliable score (de Vos *et al*. 2011:177). The reliability scores of all the sub-sections have values that exceed the recommended value of 0.700, as reflected in Table 13. This indicates an overall high degree of acceptable, consistent scoring for this study. However, question 5 has a value that is slightly lower than the standard. The primary reason for this is that the construct is newly developed and would require further testing. Table 13 represents the Cronbach's alpha score for the items that constituted the questionnaire.

Table 13: Cronbach's alpha score

Question Number	Cronbach's Alpha
2.1	0.763
2.4	0.759
3.1	0.778
4.4 - 4.8	0.705
5.5.1 - 5.5.3	0.635

4.10.2 Chi-square test

The Chi-square test of independence evaluates whether variables being examined are independent or related (Burns and Grove 2009: 499). In this study, testing of hypotheses using Chi-square tests for nominal and ordinal data, to determine the degree of association between the variables, was conducted.

4.10.3 Correlation testing

Statistically significant relationships between variables are measured using correlation tests. This study used inferential statistics, viz. Pearson's and Spearman's correlations, at a significance level (p-value) of 0.05.

Pearson's *r* is a coefficient specifying the magnitude of the relationship between two variables measured on an interval scale (Polit and Beck 2012: 737).

Spearman's rank-order correlation (Spearman's rho) is a correlation coefficient which indicates the relationship between variables measured on an ordinal scale and also measures the bivariate relationships between variables (Polit and Beck 2012: 422;743). The study reflected positive values, suggesting that there were statistically proportionate relationships between variables.

SECTION 6

4.11 Phase two: Curricula content analysis

This section explores the current psychiatric nursing and mental health curricula, after a content analysis.

4.11.1 Mental health curricula development

The curricula for the South African Nursing Council psychiatric nursing programmes R425 and R880 were qualitatively analysed. Content analysis of the curricula began with a search for recurring and consistent themes and "inconsistencies" in the documents. Themes which were interrelated were grouped (Polit and Hungler 1991: 454; Polit and Beck 2012: 119).

4.11.2 Common themes which emerged for the R425 and R880 programmes

Four themes emerged which related to caring in psychiatric nursing.

4.11.2.1 Attitudes and beliefs related to the causes of mental illness

- Knowledge of the concepts of mental health and mental illness.
- Cultural influences, values and beliefs related to the causes of mental illness.

4.11.2.2 Knowledge and information needed when caring for mental health care users

- Concepts, terminology, categories of mental illness and behavioural disorders.
- Psychopharmacology and treatment modes, viz. electro convulsive therapy, cognitive behavioural therapy, behaviour modification.
- Classification of mental health care users according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR), which describes the diagnostic categories and features of mental disorders, thereby enabling clinicians to diagnose, study and manage mental disorders (Manamela *et al*. 2003: 89;Uys and Middleton 2010: 209).
- Alternative therapy, dual diagnosis, including mental illness related to HIV and AIDS and substance-induced psychosis.
- The Mental Health Care Act No 17 of 2002.
- The management of mental health care users who are mentally challenged,

psychogeriatric persons and children and adolescents.

4.11.2.3 Skills required when caring for mental health care users

- Certain skills required were interview skills, communication skills, assessment skills, mental state examinations, functional assessments, maintenance of therapeutic and interpersonal client relations, conducting a mental state examination and history-taking. Problem identification and problem-solving skills, planning of individualised realistic nursing care interventions and evaluation of its effectiveness were also identified.

4.11.2.4 Community psychiatric nursing services

- Application of primary, secondary and tertiary principles during management of mental health care users.

4.11.3 Aspects in the curricula which were identified as dissimilar

- Of significance is the length of each programme. The psychiatric programme (R880) extends for a period of one year (South African Nursing Council 1997:2), while the R425 training programme is a four year programme. Learners are expected to meet the requirements of the Regulation R425, which indicates that “the curriculum shall consist of various fields of study, particularly in their clinical application”. Section (6 no 3) refers to psychiatric nursing science “at least two (2) academic years” (SANC Regulation R425, 1985: 4).
- Content related to nursing administration, research, death and dying are incorporated in the R880 curriculum. The R425 comprehensive nursing programme included this content in modules: ethos and professional practice, fundamental nursing science and community nursing science.

4.12 ASPECTS NEEDING GREATER ATTENTION IN PSYCHIATRIC NURSING EDUCATION

4.12.1 The aspects needing greater attention in psychiatric nursing education

Table 14 reflects the percentage of cases which indicate the frequency relative to

the total number of respondents (n=396). Seventy two percent (n=283) of respondents selected The Mental Health Care Act no 17 of 2002 as important in psychiatric nursing education. Practical management of aggression, violence and de-escalation was most frequently indicated, by 71% (n=279) of respondents. The following aspects varied from 60% to 52% : mental health stigma (59.5%); physical safety of patients, self and others (57.5%); risk assessment (56.5%); crisis assessment and intervention (53.9%); stress management (51.7%); psychological safety of patients, self and others (51.7%). The areas which the sample thought required the least amount of attention were medication management, management of psychiatric illness, communication and assertiveness skills, problem identification and management.

Table 14: Aspects needing greater attention in psychiatric nursing education

Aspects needing greater attention	**Frequency**	**Percentage of cases**
Mental Health Care Act no 17 of 2002	283	72%
Practical management of violence, aggression and de-escalation	279	71%
Mental health stigma	234	59.5%
Physical safety of patients, self and others	226	57.5%
Risk assessment	222	56.5%
Crisis assessment	214	53.9%
Crisis intervention	212	53.9%
Psychological safety of patients, self and others	203	51.7%
Stress management	203	51.7%
Medication management	187	47.2%
Management of psychiatric illnesses	174	44.3%

Communication and assertiveness	167	42.5%
Problem identification	161	41.0%
Problem management	152	38.7%
Total	2917	742.4%

4.12.2 Content needing to be included in psychiatric nursing curricula

Respondents were asked to indicate additional aspects needing to be included in the current psychiatric nursing curricula.

The comments are as follows.

- The four year nursing diploma should be extended and all categories of nurses working in psychiatric facilities should have psychiatric nurse training.
- Community and family involvement, integration of mental illness into primary health care, de-stigmatisation and awareness of mental illness, psychosocial rehabilitation, home visits by the psychiatric nurse, psychopharmacology and medication compliance and the Mental Health Care Act no 17 of 2002 need more attention.
- Further content related to the following psychiatric conditions: neuropsychiatry, mentally challenged persons, children and adolescents, forensic nursing, HIV and AIDS related to mental illness, physical illness and mental illness (dual diagnosis), psychogeriatric nursing, care of suicidal persons and post-partum psychosis was needed.
- Skills viz. practical management of aggressive patients, de-escalation, effective patient seclusion, cognitive behavioural therapy, communication and counselling skills, debriefing skills, crisis assessment and intervention, risk assessment and management and sign language need more attention.
- Holistic nursing practices, cultural and ethnical and racial tolerance in psychiatric nursing also deserve attention.

4.13 CONCLUSION

In this chapter, quantitative and qualitative data obtained were presented. Tests for reliability of the research instrument used were also presented. Descriptive

statistics, tables, figures and graphs were used to illustrate the findings of the surveys. The statistical software program (SPSS version 20.0) was the tool used to analyse data. Tests performed were as follows: Cronbach's alpha test, Chi-square test, Pearson's and Spearman's correlations. Phase Two of the study dealt with content analysis of the psychiatric nursing curricula. Thematic analysis further strengthened the explanation of quantitative findings. Chapter 5 will present a discussion of the findings made in the study.

CHAPTER 5

INTERPRETATION, DISCUSSION AND SUMMARY OF FINDINGS AND GUIDELINES

5.1 INTRODUCTION

This chapter presents a discussion and interpretation of the findings and recommendations made. The discussion will focus on demographic data, holistic nursing care and nurses' levels of comfort whilst caring for psychiatric patients. Behavioural and clinical mental health problems and challenges encountered in practice and nurses' preparedness to care for psychiatric patients is also discussed. Recommendations regarding knowledge and skill required when caring

for psychiatric patients and the areas needing greater attention in the mental health curricula will be made.

5.2 DEMOGRAPHIC FINDINGS

5.2.1 Gender

Approximately 65.9% of participants were female, while 34.1% were male. This reflects a predominance of female nurses at psychiatric facilities. These findings are in line with the gender distribution for registered nurses in KwaZulu-Natal, which indicates a larger percentage of females (92%) to males (8%) (South African Nursing Council 2013). This significant difference in gender could be due to nursing being a female dominated profession. These findings concur with those of Crabtree (2003: 716) and Bilgin and Buzlu (2006: 77), who found that in the United Arab Emirates and Istanbul, respectively nursing is commonly a female profession. Other studies also reflect a similar gender distribution (Chen, Hwu and Williams 2005: 145; Inoue *et al*. 2006: 31).The larger number of males in the current sample can be attributed to the high risk in psychiatric facilities.

5.2.2 Age

More than 30% of respondents were within the age category 30 to 39 years. These findings reflect a mature and skilled sample in psychiatric nursing care settings. In comparison, the age distribution for this age category of registered nurses or midwives in South Africa is lower (19%) (SANC 2013). These findings could suggest that a more mature group are selected to nurse psychiatric patients because of the challenges involved. These findings are similar to those of Chen *et al.* (2005: 143) who found that 28.3% (n=51) of respondents were in the age group 30 to 39. More than eight percent (n=16) of respondents were in the age category 40 to 51 years. However, 61.1% (n=110) of respondents indicated the age group 20 to 29 years.

5.2.3 Psychiatric nurse training programme

Nearly half (48.4%) of the sample completed a four year diploma course (R425 SANC 1985). In South Africa, this programme leads to a qualification in the nursing profession (SANC 1985). These findings are consistent with Lethoba, Netswera and Rankhumise (2006: 7), who found that 50% of their sample had a diploma in general nursing, psychiatric nursing and community health nursing.

5.2.4 Full-time or part-time studies

A majority (82.3%) of respondents had completed their studies full-time, followed by 14.9% of respondents who chose to study full-time and part-time. Only 2.5% studied part-time, whilst 0.3% had not completed a psychiatric programme. The South African Nursing Council Regulations R425, R880 and R212 state that the duration of these courses are four years and one academic year of 44 weeks, consecutively (SANC 1975; 1985:1; 1993: 2).

5.2.5 Participants highest qualification

Almost half of the sample had completed a four year diploma (general, psychiatric and community) and midwife (R425) and 29.8% of respondents had a psychiatric nursing diploma (R880/R212) (SANC 1975:1; 1985:1; 1993:1). Lethoba, Netswera and Rankhumise (2006: 7) found that 53% of respondents obtained a diploma in general nursing, psychiatric nursing and community health nursing. In this study only 2.9% of respondents obtained a Bachelor's degree in nursing. In South Africa the commencement and implementation of a R425 diploma programme results in there being higher numbers of graduates with a four year diploma, since this is the current basic training programme for a registered nurse or a psychiatric nurse (SANC 1985:1). Currently, a diploma in psychiatric nursing is the required qualification for registered nurses and psychiatric nurses working in psychiatric clinical fields. However, nursing education in South Africa is evolving and one of the new qualifications is a Bachelor of Nursing (SANC 2009:1). It would seem that psychiatric nurses are preparing for these changes.

5.2.6 Job title in the nursing profession

About 85% of the sample was registered nurses and psychiatric nurses. This reflects a sample that has the qualifications and skills required to manage psychiatric patients.

5.2.7 Current workplace

This study found that 45.2% of male and female respondents work at chronic and forensic wards, followed by 26% who indicated male and female acute wards. Section 41 of The Mental Health Care Act no 17 of 2002 allows a state patient who has been classified by a court in terms of the Criminal Procedure Act 51 of 1977 section 77 and 78 (as amended in 2008) to receive care, treatment and rehabilitation at designated mental health care facilities. In South Africa this Act guides nurses caring for forensic patients (Criminal Procedure Act 51 of 1977; Mental Health Care Act no 17 of 2002: 25). Given that these patients are unpredictable, the higher percentage of respondents in these units is justified. This is further supported by global and local literature, where the physical safety of psychiatric nurses in these settings was investigated (Inoue *et al.* 2006: 29; Chen *et al.* 2009: 2812; Bimenyimana *et al.* 2009: 5*;* Inoue, Kaneko and Okamura 2011:1). It was found in Taiwan that 35.0% of respondents (n=63) work in a chronic psychiatric setting (Chen *et.al* 2005: 143).

5.2.8 Years working at an in-patient psychiatric setting

About 43.7% of the sample worked for more than ten years in psychiatric facilities. This reflects a sample with extensive psychiatric nursing experience and skill, capable of coping with the challenges and difficulties encountered when caring for psychiatric patients. These results are again in line with Lethoba, Netswera and Rankhumise (2006: 7), who reported that 41.9% of respondents were employed between five and ten years, whilst 36.3% of respondents worked for more than eleven years.

5.2.9 Choice of workplace

Almost all (92.2%) of the respondents chose to work at psychiatric in-patient settings. It seems that being male played a significant role in terms of choice of workplace. In this study, 34.1% of male respondents chose psychiatric settings as their workplaces. These findings concur with a study in America, which showed that 39% of respondents were male. It is suggested that men who are not comfortable with the traditional caring and nurturing aspects of nursing tend to choose psychiatric nursing, because of its task-orientated functions, viz. physical management of patients (Torkelson and Seed 2011: 36).

A statistically significant relationship (p-value) was found between choice of workplace and level of comfort (0.000). It seems that being able to choose a workplace influenced respondents' levels of comfort in psychiatric settings.

5.3 HOLISTIC NURSING CARE, LEVELS OF COMFORT, BEHAVIOURAL AND CLINICAL MENTAL HEALTH PROBLEMS

5.3.1 Psychiatric nursing care and holistic practice

Almost the entire sample (98.5%) believed that psychiatric nursing care is an important aspect of holistic nursing practice. These findings are strengthened by the regulations for psychiatric nursing programmes (R880, R425 and R212), in which holistic nursing care of patients is emphasised. Howard and Gamble's (2011: 107) study reflected that all the respondents in their study felt that addressing the physical health needs of mentally ill patients was important. Pertaining to holism in psychiatric nursing practice, Australian studies established that nurses have more contact with patients than any other health care provider. Nurses are thus in the position to identify problem behaviours, mental illnesses and other physical problems. These researchers stated that reducing the symptoms of mental illness had a significant influence on the course and outcome of physical illnesses (Happell and Platania-Phung 2005:45). Psychiatric nursing care and holism has been defined as "seeing the whole patient" (Berg and Hallberg 2000: 323).

A statistical significant relationship (p-value) was found between “holistic nursing practice” and “age group” (0.028). This suggests that there is a significant relationship between the variables. It seems that the age of a respondent plays a role in terms of how they perceive the holistic approach in psychiatric nursing. Almost 65% of respondents in this study were in the age category 30 to 39 and 40 to 49, suggesting that a more mature sample valued holism in psychiatric nursing. This finding is in line with the psychiatric nursing curricula, which emphasise that nursing students of all age groups ensure that patients’ physical, socio-cultural, psychological and religious needs are met (SANC 1975: 4; SANC 1985: 2). This indicates that student nurses are prepared during the course of their training to render holistic nursing care. Almost the entire sample in this study agreed with this statement.

5.3.2 Common clinical mental health problems

This study found that substance abuse disorders (67%), hallucinations (65.6%) and delusional disorders (60.2%) were the most frequent conditions that patients presented with. These results are similar to findings in Taiwan, which revealed that more than half (n=92) of the patients cared for at these facilities were schizophrenic. A further 13.3% (n=24) of patients abused substances and 3.3% (n=6) of patients were diagnosed as having a delusional disorder.

Myer *et al.* (2008: 147) studied patients with HIV. Fourteen percent (n=62) of participants were depressed; 5% reported post-traumatic stress disorder and 7% (n=35) were dependent on alcohol and substances.

Bivariate Spearman’s correlation was conducted on ordinal data. A positive correlation value of 0.419 shows a directly proportional relationship between the variables “delusions” and “substance abuse disorder”. Respondents agree that patients that abuse substances are more likely to become delusional than those who do not abuse substances. Bimerew, Sonn and Kortenbout (2007:74) drew similar conclusions in Nigeria. Findings suggested that people with schizophrenia, who abuse alcohol and other substances, seem to have more frequent readmissions to psychiatric facilities.

The results of bivariate Spearman's correlation performed on "HIV and AIDS related mental illness" and "depression" shows a directly proportional relationship, with a positive value of 0.168. This suggests that respondents believed that patients presenting with HIV and AIDS related illness are also depressed. These findings seem to reflect that there is a stigma related to HIV and AIDS and mental illness, which is evident in the findings.

5.3.3 Levels of comfort

Majority of participants (86.6%) in this study said that they felt comfortable working in mental health care settings. Only 4.3% of participants were uncomfortable, while 9.1% felt uncertain about working at mental health care facilities. Interviews with professional nurses (n=22) have revealed that nurses felt competent, which could have influenced the respondents' comfort levels, since they received comprehensive training (Hlahane, Greeff and du Plessis 2006: 88).

5.3.4 Behavioural patterns and problems

The most frequently reported behavioural patterns and problems encountered by respondents were manipulative behaviour (65.3%), aggression towards others (62%) and inability to maintain self-care (50.6%). Nurses at forensic wards indicated that 62% of respondents were exposed to patient verbal aggression, whilst 29% reported being exposed to physical aggression (Daffern, Mayer and Martin 2006: 96).

The present study found that more than half of the respondents indicated that psychiatric patients needed assistance with maintenance of self-care. A study conducted in England revealed that 12% of psychiatric patients depended upon nurses to assist in meeting their self-care needs (Higgins, Hurst and Wistow 1999: 55). These findings suggest that global psychiatric facilities may have adequate resources of staffing or infrastructure, in comparison to local psychiatric facilities, which reflect a lack of resources and unequal funding at psychiatric facilities in the North West Province and Kwa Zulu-Natal, respectively (Van Rhyn and Gontsana

2004: 26; Burns 2010: 663).

Bivariate Spearman's correlation was conducted on ordinal data. A positive value of 0.380 indicated a directly proportionate relationship between suspicious patients and those who direct aggression towards others. This confirms that the more suspicious mentally ill patients become, the greater the possibility of aggression towards others.

5.4 COMMON CHALLENGES ENCOUNTERED IN PSYCHIATRIC NURSING PRACTICE

5.4.1 Specific challenges

The most common challenges faced were "patients deny mental illness" (95.7%) and "exposure to patients' unpredictable behaviour" (95.2%). A statistically significant relationship (p-value) between "burnout and frustration" and respondents "current workplace" was found at 0.000. This suggests that psychiatric nurses working at acute psychiatric wards care for unpredictable patients, resulting in increased levels of burnout and frustration. These findings indicate that the stressors related to the workplace play a role in respondents' levels of burnout and frustration. Findings of observations in Australian psychiatric facilities show that nurses were overworked, worked in unpredictable environments and felt emotionally drained (Cleary 2004:55). Jenkins and Elliott (2004:626) made similar findings in the United Kingdom. Findings of this study showed that nurses reported high levels of emotional exhaustion or "draining". High levels of depersonalisation were also reported, which led to the development of negative, callous and cynical attitudes towards patients.

5.5 PREPAREDNESS TO CARE FOR PSYCHIATRIC PATIENTS

5.5.1 Issues that were addressed and the relatedness to patient care

About half (53.9%) of the sample indicated that issues related to caring for patients with behavioural attitudes and problems were addressed very often during their

training. A further 32.7% indicated that these aspects were discussed often throughout the training period, whilst 13.4% of respondents indicated that these areas were rarely presented. A majority (91.9%) stated that the content which was presented throughout their training included content related to nursing mentally ill persons. Only 7.3% of respondents stated that the content was unrelated to mental health nursing practice.

The findings of the study are in line with previous investigations, which reflected that nurses believed that being trained in assessment skills, diagnostic skills, basic nursing skills and mental health care skills were essential to rendering comprehensive primary health services. It was also found that professional nurses who were not as comprehensively trained indicated that the above-mentioned skills were important, since they enhanced their skill in managing patients (Hlahane, Greeff and du Plessis 2006: 88).

5.5.2 Areas of focus

The areas in psychiatric nursing warranting more attention were medication management (98.9%); caring for physically ill patients (89.2%); family interventions (87.5%); cognitive behavioural therapy (86.2%) and caring for patients with a dual diagnosis (83.9%). This seems to suggest that psychiatric nurses require regular updates related to current trends in psychiatric nursing care, which is supported by Hlahane,Greeff and du Plessis (2006: 92). These findings concur with a study in England, which found that the most important training needs were management of patients with dual diagnosis (42%), working with psychotic patients (37%) and medication management (26%) (Jones and Lowe 2003: 17).

5.5.3 Respondents satisfaction levels with the amount of information presented for current qualification

Approximately 45.5% of respondents were satisfied with the extent of information presented during training and only 14.4% of respondents were rarely satisfied. Hlahane, Greeff and du Plessis (2006: 88) found, in a study of 22 professional

nurses in North West Province, that the skills lacking were primary health care competency and medication management, knowledge and skills related to the mental health care of patients.

5.5.4 Preparation to work in the area of nursing and the current Psychiatric nursing education curriculum

About 82% (81.5%) of the sample felt that they were adequately trained to care for mentally ill patients; 63.0% agreed that their colleagues were confident caring for mentally ill patients, while 61.5% concurred that the current psychiatric nursing curricula provides preparation for managing patients' clinical problems and behaviours. These findings are supported by Hlahane, Greeff and du Plessis (2006: 86). Nurses were found to be comprehensively trained and felt competent. There was thus no need for training and development. It also emerged that these nurses "seemed comfortable during the interviews and answered questions with confidence" (Hlahane, Greeff and du Plessis 2006: 86).

A statistically significant relationship (p-value of 0.38) was found between variables "training provided preparation to work with mentally ill patients" and "the type of training programme respondents completed". This shows that the type of training respondents were exposed to plays a role in respondents' preparedness to care for mentally ill patients. It is thus important that such training is ongoing, especially to those new to the field.

5.5.5 Respondents' level of confidence

There is a high level of confidence (93.4%) when caring for psychiatric patients at these facilities. Lethoba, Netswera and Rankhumise (2006: 7) found that 76% of male respondents in Gauteng public hospitals were confident nursing mentally ill patients.

A statistically significant relationship (p=value) of 0.000 was found between the variables "levels of confidence" and "age". This seems that being in a particular age category plays a significant role in terms of how respondents rated their

confidence levels in psychiatric nursing practice. This was not unusual, as with age and experience there is confidence.

5.6 SPECIFIC KNOWLEDGE AND SKILLS REQUIRED FOR PSYCHIATRIC NURSING PRACTICE

5.6.1 Further training and development

About 71.1% of respondents agreed that they required additional training and development in nursing and management of psychiatric patients; 15.7% of respondents were uncertain of the training they needed and 13.2% felt that they had no need for further training and development. The fact that 71.1% said that they needed more training seems to suggest that respondents felt more empowered and that regular training and development reduces staff injury in psychiatric settings. Employee orientation and refresher courses were found to reduce the incidence of staff assault and injuries at acute in-patient settings in the United Kingdom (Allen 2013:40).

5.6.2 Specific knowledge and skill required to enhance psychiatric nursing practice

Participants were asked to indicate what specific knowledge and skill would enhance their nursing care and practice. The aspects most frequently indicated were The Mental Health Care Act no 17 of 2002, integration of mental illness into Primary Health Care, a multidisciplinary team approach, psychosocial and substance abuse rehabilitation, family and community involvement, stigma related to mental illness, current medication trends, medication compliance and the independent function of the advanced psychiatric nurse. These findings suggest that respondents require knowledge and skills in areas that are current and dynamic as a measure to keep up with the global trends in psychiatric nursing.

These results are consistent with the findings of interviews at an in-patient psychiatric facility in Gauteng. Participants (n=21) expressed a need for the development of skills and competencies, managing of MHCUs presenting with hallucinations, delusions and dealing with acute symptoms and violence,

aggression and unacceptable sexual behaviour. It was recommended that psychiatric nurse practitioners have access to information which would improve nursing practice and ensure that they render care within the frameworks of the South African Nursing Council and The Mental Health Care Act no 17 of 2002 (Ngako, van Rensburg and Mataboge 2012: 8).

Similar results emerged from interviews with psychiatric nurses (n=9) at forensic wards in Johannesburg. One of the categories which emerged from a theme was that participants lacked sufficient knowledge and skills. A participant commented “I felt that I am not well equipped to manage that patient. I must have advanced skills to help these patients” (Tema, Poggenpoel and Myburgh 2011: 920).

Findings of a study in Australia suggested that nurses at general facilities lacked confidence when caring for mentally ill patients. It was recommended that the introduction and implementation of a holistic framework at undergraduate level of nurses’ training would ensure competence (Sharrock 2006: 9).

5.6.3 Training needs

The training needs that were most frequently indicated were training in practical management of violence, aggression and de-escalation (64.4%); the Mental Health Care Act no 17 of 2002 (55%); crisis assessment (48.3%); risk assessment (48.1%); crisis intervention (47.3%); mental health stigma (47.1%); physical safety of patients, self and others (44.0%) and stress management (42.5%). The area in training that was least identified was problem identification (24.4%). These findings suggest that, despite being trained in issues related to caring for patients with behavioural attitudes and problems, nurses are regularly exposed to aggressive and violent patients requiring de-escalation in psychiatric settings, which are potential risk environments. The need to prioritize effective aggression prevention programmes in training and development and the importance for undergraduate nursing curricula to emphasize issues related to handling of aggressive psychiatric patients in New Zealand and Taiwan, respectively, was supported by Mc Kenna *et al.* (2003:56); Chen, Hwu and Williams (2005:141).

Continuing nursing education and training was further supported in a study in

Greece (Moschovopoulou *et al.* 2011: 372). Aspects identified as requiring greater attention were management of violent and aggressive behaviour, risk assessment, communication, patient assessment skills and care of suicidal patients. Talas, Kocaöz and Akgüc (2011:197) concurred that on-the-job training at in-patient psychiatric facilities in Turkey should be made available for psychiatric nurses.

5.6.4 The type of training method and developmental programme

About 58% of respondents preferred institutional in-service training as a method of training and development. Almost half (45.9%) of the respondents indicated a one to three day course, whilst 35.1% of the respondents chose a ward or departmental in-service training. At the data-capturing phase it was discovered that respondents indicated more than one response, which explains the increased percentages. Registered nurses and psychiatric nurses at these facilities acknowledge the importance of in-service training at an institutional, ward, or departmental level. In support of these findings it was established that advanced psychiatric nurse practitioners need to be encouraged to attend in-service training, short courses and academic programmes related to the management of mental health care users who present with acute symptoms (Ngako, van Rensburg and Mataboge 2012: 8).

5.7 MENTAL HEALTH CURRICULA DEVELOPMENT

5.7.1 Aspects needing greater attention

Almost three-quarters of the sample indicated that the Mental Health Care Act No 17 of 2002 required greater attention in psychiatric nursing education and practical management of aggression, violence and de-escalation. Aspects such as mental health stigma, physical safety of patients, self and others, risk assessment, crisis assessment and intervention, stress management and the psychological safety of

patients, self and others ranged from 52% to 60%. It would seem that issues related to stigma and psychiatric nursing suggest that the stigma surrounding mental illness is a constant challenge for nurses. The findings of interviews and observations made by Mavundla (2000: 1574) also suggest that nurses at a hospital in Durban held negative perceptions of patients with a mental illness.

Zeng *et al.* (2013: 513) suggested that the curriculum for psychiatric nurse training in China include training skills for screening patients at risk for violence, handling of patients emotional and behavioural problems and include de-escalation techniques.

The areas requiring the least amount of attention in this study were medication management, management of psychiatric illness, communication and assertiveness skills and problem identification and management.

In support of these findings, it was found that psychiatric nurse practitioners should participate in regular updates and in-service training related to the management of psychiatric patients. The contents should include skills when dealing with acute patients and symptom management of hallucinations, delusions, patient violence and aggressive behaviour and inappropriate sexual behaviour (Ngako, van Rensburg and Mataboge 2012: 8).

A study with qualified mental health nurses in England showed that the aspects which need to be included in training are risk assessment, policy and procedural aspects, management and leadership. Management of psychosocial issues, personality disorders, psychosis, dual diagnosis and management of violent and aggressive patients need attention (Jones and Lowe 2003: 17).

5.8 GUIDELINES TO STRENGTHEN NURSING EDUCATION

The researcher will attend to the themes that will arise and the patterning of the themes which emerge from content analysis of the curricula and the responses from the survey. Phase Two of the study was linked to objectives three and four. The guidelines were described and discussed, based upon the relevant themes which emerged from the analysis of the curricula for the psychiatric nursing programmes regulations R880 and R425.

- **Guideline one: Care and management of clinical mental health problems, behavioural patterns and problems**

Analysis of the contents of the curricula revealed that these aspects are included. However, on review of the curricula, policy-makers should be informed of these findings. Respondents indicated that further training, development and updates related to these areas would enhance nursing care and practice. Nursing management and nursing education could facilitate and co-ordinate staff development programmes and workshops. Of significance is the result of the present study, which shows that 72% of respondents indicated that the Mental Health Care Act No 17 of 2002 requires emphasis in nursing education.

- **Guideline two: Facilitation of support in coping with challenges encountered**

Employee updates, in-service training and development concerned with negative encounters experienced by psychiatric nurses can be arranged by nursing management and assisted by nursing education.

- **Guideline three: Skills needed when caring for these patients**

Respondents indicated that skills, viz. practical management of aggressive patients, de-escalation, effective seclusion of patients, cognitive behavioural therapy, communication and counselling skills, debriefing skills, crisis assessment and intervention, risk assessment and management and sign language should receive greater attention in the curricula. These aspects are included in the curricula, however policy-makers could further strengthen these aspects.

- **Guideline four: Types of skill, training and development**

Majority of respondents preferred institutional in-service training, a one to three-day course was the second option and just over a third of respondents indicated ward or departmental in-service training. Nursing management and nursing education could facilitate such programmes and encourage psychiatric nurses to attend them to keep updated with current developments in psychiatric nursing. These findings suggest that a greater challenge which nurses are exposed to left

respondents feeling unprepared.

It is clear that aspects reported as needing greater attention in the curricula are present in the current curricula, however additional factors were increasing the period of training for the programmes, especially the R425 programme, which currently has a six-month psychiatric module. Another factor to consider would be to increase the number of periods for the content seen as needing attention.

5.9 LIMITATIONS OF THE STUDY

- The population included in this study was limited to registered nurses and psychiatric nurses. There are other categories of nurses, viz. enrolled nurses and enrolled nursing assistants caring for psychiatric patients in these facilities who could be included in another study.
- Three of the facilities included in the study were situated in health care districts, the EThekwini Health District, the Amajuba Health District and the Sisonke Health Care District, which resulted in extensive travel distances during the data collection process.
- The data collection process commenced in June 2013 and was completed at the end of July 2013. A majority of psychiatric nurses at these facilities were on annual leave, which resulted in the researcher rescheduling appointments for data collection.
- Due to a transport unrest matter in June 2013 the researcher had to arrange another date for data collection at the specific facility. This further delayed the data collection process.

5.10 CONCLUSION

This study found that almost all respondents believed that psychiatric nursing care is essential in holistic nursing practice. There were high levels of comfort and confidence indicated in favour of working at in-patient psychiatric facilities. These findings could be related to the sample having a choice in their current place of work. The age categories of more than 60% of respondents were reported to be

from 30 to 49 years, which could also influence the increased levels of comfort and confidence.

The experience of respondents working at psychiatric facilities is evident in the findings, which show that more than 40% of the sample worked for more than 10 years. Psychiatric nurses commonly encounter patients who deny that they suffer from mental illness and display unpredictable behaviour. The skill and competence of respondents to manage challenges encountered in nursing practice is dependent upon training and development. Significantly more than 50% of respondents indicated that issues related to caring for patient behaviours and problems were addressed very often during their training. The study found that most respondents felt that they were adequately prepared to care for mentally ill patients. However, there were aspects commonly identified as needing greater attention in the psychiatric nursing curriculum. These were the Mental Health Care Act no 17 of 2002 and practical management of aggression, violence and de-escalation of psychiatric patients.

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Appendix 1

Dear participant

Warmest greetings to you. Welcome to my study. My name is Perrene Dale Joubert. I am currently studying toward a Masters of Nursing degree at Durban University of Technology.

The title of my study is: An investigation into the roles of registered nurses and psychiatric nurses at in-patient psychiatric facilities, and its implications for nursing education in KwaZulu-Natal.

The objectives of the study are:

1. To explore which mental health problems are most commonly seen amongst psychiatric patients at these facilities.
2. To investigate the challenges faced by psychiatric nurses when caring for psychiatric patients.
3. To investigate what specialized knowledge and skills are required when nursing such patients.
4. To investigate whether their education and training prepared them adequately to deal with psychiatric patients and suggest guidelines to strengthen nursing education.

The survey has utilized segments from two questionnaires that have been adapted from instruments developed by Jones and Lowe (2003); Lesinskiene, Jegorova, and Ranceva (2007). Permission has been obtained from these researchers to utilize and adapt segments from the questionnaires for the study.

A definition of a psychiatric nurse is included in the questionnaire to give you clarity and assist with your responses. The study has been reviewed by the Faculty of Health Science Research and Higher Degrees Committee and has received ethical approval from Durban University of Technology Institutional Research Ethics Committee.

Kindly complete all sections of the questionnaire. Section one does not require your identifying details. All information submitted will be handled confidentially and your anonymity will be ensured. If you wish to comment on any question or section please use the areas on the side or bottom of the pages. All comments will be read and considered. Participation in this study is voluntary. You may withdraw from the study at any time without obligation. Consent to participate is required. You need to complete the attached form indicating your willingness to participate. Should you have any queries kindly contact the researcher using the details below.

The data collection procedure:

The researcher will not have direct contact with participants. The study will involve participants completing the questionnaire at their workplace. Written permission will be requested to conduct the study from the Department of Health KwaZulu-Natal Research and Knowledge Management. Once this permission has been granted, written permission will be requested from the Chief Executive Officers and Nursing Service Managers to conduct the study. A meeting will be arranged with the Nursing Service Managers to discuss the purpose and value of the study. At this meeting the procedure for data collection will be explained, dates and times for the delivery and collection of the questionnaires negotiated and the inclusion and exclusion criteria will be explained. The ethical

considerations will be reinforced. The purpose, nature, conduct, benefits, and risks of the study will be explained to the participants by the researcher. The consenting participants will complete a letter of information supplied by the researcher and research assistant. Questions and concerns raised by the participants will be answered by the researcher. A research assistant who is familiar with nursing will distribute and collect questionnaires. The researcher will oversee the data collection procedure. The questionnaires will be delivered to the Nursing Service Managers and or the Operational Managers personally with a sealed box. The latter will be stored in a locked venue where participants, can at times drop off completed questionnaires. The researcher will collect the sealed drop off box a month later or on an agreed date. The researcher will send follow-up letters to the participants two or three weeks from the delivery date of the original questionnaire to ensure a high response rate is obtained as described in (de Vos *et al*. 2011).

Thank you for participating in my study.

Sincerely P.D.Joubert (Mrs.)

Researcher: Mrs. P.D.Joubert - Edendale Nursing Campus – 033 3456810

Supervisor: Dr. R. Bhagwan PhD (Community and Developmental Disciplines UKZN).
Durban University of Technology – 031 373 2197
Email: bhagwanr@dut.ac.za

.....

Section 1

This section includes questions related to demographic and other personal and professional background information.

Instruction: Indicate the most appropriate response with an X in the block provided.

1.1. Gender

- ☐ Male
- ☐ Female

1.2. Indicate your age group

- ☐ 18-29
- ☐ 30-39
- ☐ 40-49
- ☐ 50-59
- ☐ 60 +

1.3. Indicate which psychiatric nurse training programme you have completed.

- ☐ Advanced Psychiatric nurse training programme
- ☐ 1 year Diploma in Psychiatric Nursing Science
- ☐ 4 year Comprehensive Programme

1.4. Indicate whether the training programme in 1.3. was full time or part time.

- ☐ Full time
- ☐ Part time

1.5. Indicate your highest qualification.

- ☐ Diploma in Psychiatric nursing
- ☐ Diploma in Nursing (General, Psychiatric and Community) and Midwife
- ☐ Baccalaureate Degree (Administration and Education)
- ☐ Advanced Diploma in Psychiatric nursing
- ☐ Master's Degree in Psychiatric nursing
- ☐ PhD Psychiatric nursing

1.6. Which job title in the nursing profession best describes you?

- ☐ Operational manager
- ☐ Registered psychiatric nurse

1.7. Where do you work currently?

- ☐ Male acute in-patient ward
- ☐ Female acute in-patient ward
- ☐ Male sub-acute in-patient ward
- ☐ Female sub-acute in-patient ward
- ☐ Male chronic in-patient ward
- ☐ Female chronic in-patient ward
- ☐ Male forensic ward
- ☐ Female forensic ward
- ☐ Learner liaison

1.8. How long have you been working in an in-patient mental health care setting?

- ☐ < 1 year
- ☐ 1-5 years
- ☐ 6-10 years
- ☐ > 10 years
- ☐ Indicate in this block the number of years working in the health care setting.

1.9. Was it your choice to work in a mental health care setting?

- ☐ Yes
- ☐ No

If not, specify reasons for same below:

……

……

Section 2

To assist you in responding to the questions below, a definition of a psychiatric nurse is provided.

A psychiatric-mental health registered nurse is one who has competence in caring for patients with mental health issues, problems and psychiatric disorders. The psychiatric nurse obtains specialized skills, abilities and knowledge through education, training and experience (American Nurses Association (ANA), 2007 cited in Townsend 2009).

A Registered Psychiatric nurse in the South African context is defined as nurse who has met the requirements of the SANC Regulation 1995 (R880) Diploma in Psychiatric nursing, which is a 12 month programme.

-A registered psychiatric nurse has met the requirements of the SANC Regulation 1985 (R425) Diploma in (General, Psychiatric and Community) and Midwife. This is a 6 month module incorporated in the (R425) programme, which runs over a 4 year period.

2.1. Do you believe that psychiatric nursing is an important part of holistic nursing practice?

Strongly disagree	Disagree	Uncertain	Agree	Strongly agree
1	2	3	4	5

2.2. Below is a list of common clinical mental health problems.

Indicate those which patients present with in your care by circling the appropriate response.

2.2.1. Hallucinations	never	rarely	often	very often	all the time
2.2.2. Delusions	never	rarely	often	very often	all the time
2.2.3. Anxiety disorders	never	rarely	often	very often	all the time
2.2.4. Depression	never	rarely	often	very often	all the time
2.2.5. Suicidal ideation	never	rarely	often	very often	all the time
2.2.6. Bipolar mood disorder	never	rarely	often	very often	all the time
2.2.7. Cognitive disorder e.g. dementia /delirium	never	rarely	often	very often	all the time
2.2.8. Substance abuse disorder	never	rarely	often	very often	all the time
2.2.9. HIV& AIDS related mental illness	never	rarely	often	very often	all the time

2.3. Describe your levels of comfort in terms of working in a mental health care setting. Indicate your response by circling the number that best describes your response.

Very uncomfortable	Uncomfortable	Uncertain	Comfortable	Very comfortable
1	2	3	4	5

2.4. Below is a list of behavioral patterns and problems that psychiatric patients display. Indicate those which you encounter in your setting by circling your response.

2.4.1. Manipulative	never	rarely	often	very often	all the time
2.4.2. Suspicious	never	rarely	often	very often	all the time
2.4.3. Withdrawn	never	rarely	often	very often	all the time
2.4.4. Self-directed aggression	never	rarely	often	very often	all the time

2.4.5. Aggression directed towards others	never	rarely	often	very often	all the time
2.4.6. Disorientation	never	rarely	often	very often	all the time
2.4.7. Impaired verbal communication	never	rarely	often	very often	all the time
2.4.8. Inability to maintain self-care	never	rarely	often	very often	all the time
2.4.9. Sleep disturbances	never	rarely	often	very often	all the time
2.4.10. Memory problems	never	rarely	often	very often	all the time

Section 3

This section relates to the most common challenges faced by psychiatric nurses when dealing with mentally ill patients. Indicate the challenges or problems you face in practice.

Statement	**strongly disagree**	**disagree**	**uncertain**	**agree**	**strongly agree**
3.1. Psychiatric nurses experience higher levels of stress or emotional exhaustion.	1	2	3	4	5
3.2. Psychiatric nurses are exposed to increased levels of aggression or violence.	1	2	3	4	5
3.3. Psychiatric nurses are exposed to unpredictable behavior from patients.	1	2	3	4	5
3.4. Psychiatric nurses experience feelings of anger, frustration.	1	2	3	4	5
3.5. Psychiatric nurses experience high levels of burn out and frustration.	1	2	3	4	5
3.6. Psychiatric nurses have a negative perception of psychiatric patients.	1	2	3	4	5
3.7. Shortage of psychiatric nurses adds to emotional exhaustion and job dissatisfaction.	1	2	3	4	5
3.8. Lack of support and appreciation from management and the multidisciplinary team increases workplace dissatisfaction.	1	2	3	4	5
3.9. Psychiatric nurses work in environments which have inadequate facilities.	1	2	3	4	5
3.10. Psychiatric nurses face patients who refuse to take psychiatric medication.	1	2	3	4	5
3.11. Psychiatric nurses encounter patients who deny having mental illness.	1	2	3	4	5

Section 4

This section will investigate psychiatric nurses level of preparedness to care for psychiatric patients.

4.1. In your training as a psychiatric nurse how often were issues pertaining to the care of patients with behavioral attitudes and problems presented and discussed?

Never	Rarely	Often	Very often	All the time

4.2. If issues were addressed did it include specific content related to nursing mentally ill individuals?

- ☐ Yes
- ☐ No

4.3. If yes, did this area of education focus on:

	Yes	No
4.3.1. Family interventions.		
4.3.2. Care for physical health of patients.		
4.3.3. Medication management.		
4.3.4. Working with dual diagnosis.		
4.3.5. Cognitive-behavioral therapy for patients presenting with delusions and hallucinations.		

4.4. In terms of your current training were you satisfied with the amount of information presented?

Never	Rarely	Often	Very often	All the time

4.5. In terms of your current area of work, did this training adequately prepare you to deal with mentally ill individuals?

Strongly disagree	Disagree	Uncertain	Agree	Strongly agree
1	2	3	4	5

4.6. The current psychiatric nursing education curriculum has provided preparation for handling clinical problems or behaviors displayed by psychiatric patients. Circle your response below.

Strongly disagree	Disagree	Uncertain	Agree	Strongly agree
1	2	3	4	5

4.7. Rate your level of confidence when caring for psychiatric patients.

Very unconfident	Unconfident	Uncertain	Confident	Very confident
1	2	3	4	5

4.8. Do you feel that your colleagues are confident caring for psychiatric patients?

Strongly disagree	Disagree	Uncertain	Agree	Strongly agree
1	2	3	4	5

Section 5

This section investigates the specific knowledge and skills psychiatric nurses require when caring for psychiatric patients.

5.1. Do you feel that you require further training and development in nursing and management of psychiatric patients?

Strongly disagree	Disagree	Uncertain	Agree	Strongly agree
1	2	3	4	5

5.2. If your response to above question was agree or strongly agree, indicate what specific knowledge and skill you require in order to enhance your nursing care and practice.

5.2.1.

5.2.2.

5.2.3.

5.2.4.

5.2.5.

5.3. Below is a list of training needs. Indicate which areas you believe you need further training in.

- ☐ Mental Health Care Act no 17 of 2002
- ☐ Crisis assessment
- ☐ Crisis intervention
- ☐ Risk assessment
- ☐ Physical safety of patients, self and others
- ☐ Psychological safety of patients, self and others
- ☐ Problem identification
- ☐ Problem management
- ☐ Practical management of violence, aggression and de-escalation
- ☐ Management of psychiatric illnesses
- ☐ Communication and assertiveness skills
- ☐ Stress management
- ☐ Mental health stigma
- ☐ Medication management

5.4. Indicate what type of method of training and development programme would be preferred.

- ☐ 1-3 day short course
- ☐ Institutional in-service training
- ☐ Ward / departmental in-service training

5.5. For each statement below indicate your response by circling the appropriate number.

	Strongly disagree	**Disagree**	**Uncertain**	**Agree**	**Strongly agree**
1. Newly appointed induction programmes should include training on the management of clinical and behavior problems.	1	2	3	4	5
2. Psychiatric nurses should attend 6 monthly /annual refresher training and development on management of clinical and behavior problems displayed by psychiatric patients.	1	2	3	4	5
3. Psychiatric nurses should attend in-service training and updates on current relevant matters in mental health care nursing.	1	2	3	4	5

Section 6.

Mental health curricula development

6.1. Which of the following aspects require greater attention in psychiatric nursing education? Indicate the aspects with an X in the block provided.

- ☐ Mental Health Care Act no 17 of 2002
- ☐ Crisis assessment
- ☐ Crisis intervention
- ☐ Risk assessment
- ☐ Physical safety of patients, self and others
- ☐ Psychological safety of patients, self and others
- ☐ Problem identification
- ☐ Problem management
- ☐ Practical management of violence, aggression and de-escalation
- ☐ Management of psychiatric illnesses
- ☐ Communication and assertiveness skills
- ☐ Stress management
- ☐ Mental health stigma
- ☐ Medication management

6.2. Based on your experience what further aspects need to be included in current psychiatric nursing curricula.

6.1.1. ……...
6.1.2. ……
6.1.3. ……
6.1.4. ……
6.1.5. ……

Thank you for your participation

Appendix 2 a

Perrene Dale Joubert Student Number - 21237178

Dear Perrene,

Please use the questionnaire for your reseach and adapt it according the context if needed. The Lickert scale numbers were entered into the data basis and statystical analysis made using methods that are descriebed in the publication looking for the statistical significance between variables, and that presented in the reults section. It was quite long ago, but nothing special as fa ras I remember. You could be free to use and adapt any parts of the questionnaire. I'm happy to hear that you are interested.

Good luck with your study,

Kind regards,

Sigita

-----Original Message-----

From: Perrene Dale Joubert [mailto:perrenejoubert@yahoo.com]

Sent: Sunday, May 20, 2012 2:47 PM

To: sigita.lesinskiene@mf.vu.lt

Subject: Re:Article of young psychotic patients

Dear Sigita

I Mrs Perrene Dale Joubert am currently registered in a Masters Post Graduate Programme with Durban University of Technology in Kwa Zulu Natal,South Africa and am being supervised by Dr R.Bhagwan from the institution.My area of interest is Psychiatric nursing.I have accessed your article "Nursing of young psychotic patients :analysis of work environments and attitudes" which was published in the Journal of Psychiatric and Mental Health Nursing,2007,14,758-764". I am requesting your permission to have a copy of the questionnaire.

Should my request meet with your approval,I request your written permission / consent to utilise segments of your questionnaire and adapt it to the South African context.I will also request that you forward me written

consent to utilise and adapt segments of the questionnaire.Please inform me

if there were any forms of scoring used in the analysis of the questionnaire

and would it be possible for you to furnish me with these details.Should you

grant permission for me to use the segments of the questionnaire I will

acknowledge your work and send you a copy of the findings.I have tried to

contact Nadia Ranceva but have not received a response to date.

Thanking you

Perrene Joubert

Appendix 2 b

Perrene Dale Joubert Student Number - 21237178

Dear Perrene

Thank you for your email. I am happy for you to use sections of the questionnaire. There was no particular scoring used.

I look forward to hearing how your study goes and your findings.

Best wishes

Julia

****

Dr. Julia Jones

Reader in Mental Health

School of Health Sciences

City University London

Philpot Street

London E1 2EA

Tel: 020 7040 5485 (direct)

Fax: 020 7040 5811

Email: J.Jones-4@city.ac.uk

From: Perrene Dale Joubert [perrenejoubert@yahoo.com]

Sent: 14 May 2012 19:41

To: Jones, Julia

Subject: Re: Questionnaire for What education and training do mental health nurses want

Dear Julia

I Mrs Perrene Dale Joubert am currently registered in a Masters Post Graduate Programme with Durban University of Technology in Kwa Zulu Natal,South Africa and am being supervised by Dr R.Bhagwan from the institution.My area of interest is Psychiatric nursing.I have accessed your article "What education and training do mental health nurses want? A survey of qualified mental health nurses in acute settings in the UK" Royal College of Nursing 2003.

Should my request meet with your approval,I request your written permission / consent to utilise segments of your questionnaire and adapt it to the South African context.I will also request that you forward me written consent to utilise and adapt segments of the questionnaire.Please inform me if there were any forms of scoring used in the analysis of the questionnaire and would it be possible for you to furnish me with these details.Should you grant permission for me to use the questionnaire I will acknowledge your work and send you a copy of the findings.

Thanking you

Perrene Joubert

Appendix 3

LETTER OF INFORMATION

Warmest greetings to you. Welcome to my study.

Title of the Research Study: An investigation into the roles of registered nurses and psychiatric nurses at in-patient psychiatric facilities, and its implications for nursing education in KwaZulu-Natal.

Principal Investigator/researcher: Mrs. P.D.Joubert Qualification**:** B CUR Administration / Education.

Co-Investigator/s/supervisor/s: Dr. R. Bhagwan Qualification**:** PhD (Community and Developmental Disciplines UKZN).

Brief Introduction: "The World Health Organization (WHO) defined health as a state of complete physical, mental and social well-being" (Happell 2004:41). In order to render a holistic service, psychiatric nurses must be able to deal with the psychological dimension along with providing physical care.

Purpose of the Study: To investigate the roles of registered nurses and psychiatric nurses at in-patient psychiatric facilities, the primary challenges in caring for these patients and their educational preparedness to deal with this specialized area of nursing practice.

Outline of the Procedures: The researcher will not have direct contact with participants. The study will involve participants completing the questionnaire at their workplace. Written permission will be requested to conduct the study from the Department of Health KwaZulu-Natal Research and Knowledge Management. Once this permission has been granted, written permission will be requested from the Chief Executive Officers and Nursing Service Managers to conduct the study. A meeting will be arranged with the Nursing Service Managers to discuss the purpose and value of the study. At this meeting the procedure for data collection will be explained, dates and times for the delivery and collection of the

questionnaires negotiated and the inclusion and exclusion criteria will be explained. The ethical considerations will be reinforced. The purpose, nature, conduct, benefits, and risks of the study will be explained to the participants by the researcher. The consenting participants will complete a letter of information supplied by the researcher and research assistant. Questions and concerns raised by the participants will be answered by the researcher. The questionnaires will be delivered to the Nursing Service Managers and or the Operational Managers personally with a sealed box. The latter will be stored in a locked venue where participants, can at times drop off completed questionnaires. A research assistant who is familiar with nursing will distribute and collect questionnaires. The researcher will oversee the data collection procedure. The researcher will collect the sealed drop off box a month later or on an agreed date. The researcher will send follow-up letters to the participants two or three weeks from the delivery date of the original questionnaire to ensure a high response rate is obtained as described by (de Vos *et al*. 2011).

Risks or Discomforts to the Participant: There will be no risks to the participants in the study.

Benefits: The intended benefits are to enhance the quality of nursing care in psychiatric facilities, address the challenges which psychiatric nurses encounter and propose recommendations for mental health nursing education.

Reason/s why the Participant May Be Withdrawn from the Study: A participant may withdraw from the study at any time with no adverse consequences on the participant.

Remuneration: There will be no remuneration for the participant or the researcher during or on conclusion of the study.

Costs of the Study: There are no costs incurred for the participant in the study.

Confidentiality: Confidentiality and anonymity of participant information will be maintained at all times. All information will be stored under lock and key, with researcher access only.

Research-related Injury: The researcher does not foresee any risks or research related injuries during the data collection process which participants could be exposed to. There will be no risk or injury compensation to participants in the study.

Persons to Contact in the Event of Any Problems or Queries:

Researcher: Mrs. P.D.Joubert - Edendale Nursing Campus – 033 3456810

Supervisor: Dr. R. Bhagwan PhD (Community and Developmental Disciplines UKZN).

Durban University of Technology – 031 373 2197

Email: bhagwanr@dut.ac.za

Please contact the researcher, my supervisor or the Institutional Research Ethics administrator on 031 373 2900. Complaints can be reported to the DVC: TIP, Prof F. Otieno on 031 373 2382 or dvctip@dut.ac.za.

Appendix 3

CONSENT

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, _____ (name of researcher), about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: _____,
- 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 **Date** **Time** **Signature / Right Thumbprint**

I, _____ (name of researcher) 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 4

DURBAN UNIVERSITY of TECHNOLOGY

INSTITUTIONAL RESEARCH ETHICS COMMITTEE (IREC)

10 April 2013

IREC Reference Number: **REC 73/12**

Mrs P D Joubert
100 Chase Valley Road
Pietermaritzburg
3201

Dear Mrs Joubert

An investigation into the roles of registered nurses and psychiatric nurses at in-patient psychiatric facilities, and its implications for nursing education in KwaZulu-Natal

I am pleased to inform you that Full Approval has been granted to your proposal REC 73/12.

The Proposal has been allocated the following Ethical Clearance number IREC 026/13. Please use this number in all communication with this office.

Approval has been granted for a period of one year, before the expiry of which you are required to apply for safety monitoring and annual recertification. Please use the Safety Monitoring and Annual Recertification Report form which can be found in the Standard Operating Procedures [SOP's] of the IREC. This form must be submitted to the IREC at least 3 months before the ethics approval for the study expires.

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. In addition, you will be responsible to ensure gatekeeper permission.

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

Yours Sincerely

Dr D F Naude
Chairperson: IREC

Appendix 5.1

The Chief Executive Officer: Dr Okali

The Nursing Service Manager: Mrs Z. Nyuswa

Ekuhlengeni Hospital

P. O. Box 3

Umbogintwini

4120

18 April 2013

Request to conduct a Research Project

I am currently studying toward a Master of Nursing Degree at Durban University of Technology. I will request permission from the Health Research and Knowledge Management Committee to conduct a research project in health care facilities in KwaZulu-Natal. The facilities to be included in my study are in- patient mental health care facilities.

The purpose of this study is to investigate the roles of registered nurses and psychiatric nurses at in-patient psychiatric facilities, the primary challenges in caring for these patients and their educational preparedness to deal with this specialized area of nursing practice. The intention of this study is to enhance the quality of nursing care in mental health care facilities in KwaZulu-Natal.

Permission has been obtained from Durban University of Technology Departmental Research Committee, Faculty Research Committee and the Institutional Ethics and Research Committee: Ethical Clearance Number: IREC 026/13

Persons to Contact in the Event of Any Problems or Queries:

Researcher: Mrs. P.D.Joubert - Edendale Nursing Campus – 033 3456810

Email: perrenejoubert@yahoo.com

Supervisor: Dr. R. Bhagwan PhD (Community and Developmental Disciplines UKZN).

Durban University of Technology – 031 373 2197

Email:bhagwanr@dut.ac.za

Please contact the researcher, my supervisor or the Institutional Research Ethics administrator on 031 373 2900. Complaints can be reported to the DVC: TIP, Prof F. Otieno on 031 373 2382 or dvctip@dut.ac.za.

Sincerely

P.D.Joubert (Mrs)

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

EKUHLENGENI PSYCHIATRIC HOSPITAL
P O Box 3, Umbogintwini, 4126
Tel.: 031 905 4775 Fax.:
Email: onyeka.okoli@kznhealth.gov.za
:
www.kznhealth.co.za

Enquiries: Dr. O. Okoli
Telephone: ext 7507

06 May 2013

Dear Mrs. P.D Joubert,

RE: Request to Conduct a Research Project at Ekuhlengeni Psychiatric Hospital

The aforementioned refers:

Authority to carry out your research studies is hereby granted. Please note that the following conditions are met before your data collection: -

1. Approval must be received from Health Research and Knowledge Management Sub-Committee of the Department of Health
2. The institution will not offer any form of material or logistic support towards your study
3. The studies/data collection must comply with the research protocol as approved by the ethics committee

We wish you all the best in your studies.

Yours faithfully,

[redacted]

DR. O.A OKOLI
HOSPITAL CEO (Acting)
EKUHLENGENI PSYCHIATRIC HOSPITAL

Appendix 5.2

The Chief Executive Officer: Mrs. N.T.Nxaba

The Nursing Service Manager: Ms. T. Ngcobo

Fort Napier Hospital

P O Box 370

Pietermaritzburg

3200

18 April 2013

Request to conduct a Research Project

I am currently studying toward a Master of Nursing Degree at Durban University of Technology. I will request permission from the Health Research and Knowledge Management Committee to conduct a research project in health care facilities in KwaZulu-Natal. The facilities to be included in my study are in- patient mental health care facilities.

The purpose of this study is to investigate the roles of registered nurses and psychiatric nurses at in-patient psychiatric facilities, the primary challenges in caring for these patients and their educational preparedness to deal with this specialized area of nursing practice. The intention of this study is to enhance the quality of nursing care in mental health care facilities in KwaZulu-Natal.

Permission has been obtained from Durban University of Technology Departmental Research Committee, Faculty Research Committee and the Institutional Ethics and Research Committee: Ethical Clearance Number: IREC 026/13

Persons to Contact in the Event of Any Problems or Queries:

Researcher: Mrs. P.D.Joubert - Edendale Nursing Campus – 033 3456810

Email: perrenejoubert@yahoo.com

Supervisor: Dr. R. Bhagwan PhD (Community and Developmental Disciplines UKZN).

Durban University of Technology – 031 373 2197

Email:bhagwanr@dut.ac.za

Please contact the researcher, my supervisor or the Institutional Research Ethics administrator on 031 373 2900. Complaints can be reported to the DVC: TIP, Prof F. Otieno on 031 373 2382 or dvctip@dut.ac.za.

Sincerely

P.D.Joubert (Mrs)

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

FORT NAPIER HOSPITAL
P.O. Box 370, Pietermaritzburg, 3200
01 Devonshire Road, Pietermaritzburg, 3200
Tel.: 033 - 3454221, Fax.: 033 - 3455730
www.kznhealth.gov.za

Enquiries: T.N. Ngcobo
EXT No.: 4314

24th May 2013

To: Mrs. P. Joubert

Dear Madam

Re: Research Project

On behalf of Fort Napier Hospital please note that permission has been granted for you to conduct the above study titled:

An investigation into the roles of psychiatric nurses and registered nurses at an in- patient psychiatric facility and its implications for Nursing Education in KZN.

Please make arrangements to meet with the Nursing Manager before the commencement of your study.

Thank you

[redacted]

Mrs. N. Nxaba - CEO

FORT NAPIER
PO[illegible]70
24 -05- 2013
PIETERMARITZBURG 3200
FORT NAPIER

Appendix 5.3

The Chief Executive Officer: Ms. H. Hlela

The Nursing Service Manager: Mrs. H.S.L. Khanyi

Madadeni Hospital

P/ Bag X 6642

Newcastle

2940

18 April 2013

Request to conduct a Research Project

I am currently studying toward a Master of Nursing Degree at Durban University of Technology. I will request permission from the Health Research and Knowledge Management Committee to conduct a research project in health care facilities in KwaZulu-Natal. The facilities to be included in my study are in- patient mental health care facilities.

The purpose of this study is to investigate the roles of registered nurses and psychiatric nurses at in-patient psychiatric facilities, the primary challenges in caring for these patients and their educational preparedness to deal with this specialized area of nursing practice. The intention of this study is to enhance the quality of nursing care in mental health care facilities in KwaZulu-Natal.

Permission has been obtained from Durban University of Technology Departmental Research Committee, Faculty Research Committee and the Institutional Ethics and Research Committee: Ethical Clearance Number: IREC 026/13

Persons to Contact in the Event of Any Problems or Queries:

Researcher: Mrs. P.D.Joubert - Edendale Nursing Campus – 033 3456810

Email: perrenejoubert@yahoo.com

Supervisor: Dr. R. Bhagwan PhD (Community and Developmental Disciplines UKZN).

Durban University of Technology – 031 373 2197

Email:bhagwanr@dut.ac.za

Please contact the researcher, my supervisor or the Institutional Research Ethics administrator on 031 373 2900. Complaints can be reported to the DVC: TIP, Prof F. Otieno on 031 373 2382 or dvctip@dut.ac.za.

Sincerely

P.D.Joubert (Mrs)

health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Tel: 034 –3288007
Fax: 034 – 3291595
E-mail:
Hlengiwe.hlela@kznhealth.gov.za

TO	:	**Mrs. P. D. Joubert**
CC		
FROM	:	**Dr. H. A. Hlela**
DATE	:	**2013-04-18**
RE	:	**Permission to conduct the research project**

Permission is hereby granted by Madadeni hospital to conduct a research project investigating "**the roles of registered nurses and psychiatric nurses at in-patient psychiatric facilities, the primary challenges in caring for these patients and their educational preparedness to deal with this specialized area of nursing".**

Kindly note the following:

1. You are bound by the policies, protocols and guidelines of the Department of Health with regards to research for the duration of the study.
2. There shall be no disruption of service delivery as a result of your study.
3. The research can only commence when you provide proof of approval from the Provincial Health Research Committee in the KZN Department of Health.
4. The hospital will not provide any resources towards your study.
5. The hospital must be given a copy of the findings before the publication of the study.

Thank you,

[redacted] **ACTING CEO**

Appendix 5.4

The Chief Executive Officer: Mrs. Z.G. Mfeka

The Nursing Service Manager: Mr. T. Mahlase

The Institutional Research Committee Chair Person: Dr. H. King

Town Hill Hospital

P. O. Box 400

Pietermaritzburg

3200

23 April 2013

Request to conduct a Research Project

I am currently studying toward a Master of Nursing Degree at Durban University of Technology. I will request permission from the Health Research and Knowledge Management Committee to conduct a research project in health care facilities in KwaZulu-Natal. The facilities to be included in my study are in- patient mental health care facilities.

The purpose of this study is to investigate the roles of registered nurses and psychiatric nurses at in-patient psychiatric facilities, the primary challenges in caring for these patients and their educational preparedness to deal with this specialized area of nursing practice. The intention of this study is to enhance the quality of nursing care in mental health care facilities in KwaZulu-Natal.

Permission has been obtained from Durban University of Technology Departmental Research Committee, Faculty Research Committee and the Institutional Ethics and Research Committee: Ethical Clearance Number: IREC 026/13

Persons to Contact in the Event of Any Problems or Queries:

Researcher: Mrs. P.D.Joubert - Edendale Nursing Campus – 033 3456810

Email: perrenejoubert@yahoo.com

Supervisor: Dr. R. Bhagwan PhD (Community and Developmental Disciplines UKZN).

Durban University of Technology – 031 373 2197

Email:bhagwanr@dut.ac.za

Please contact the researcher, my supervisor or the Institutional Research Ethics administrator on 031 373 2900. Complaints can be reported to the DVC: TIP, Prof F. Otieno on 031 373 2382 or dvctip@dut.ac.za.

Sincerely P.D.Joubert (Mrs)

health

Department:
Health
PROVINCE OF KWAZULU-NATAL

TOWN HILL HOSPITAL
P.O BOX 400
PIETERMARITZBURG
3200
Tel.: (033) 341 5627
Fax: (033) 345 5720
Cell: 083 777 3749
E-mail: howard.king@kznhealth.gov.za
hking@samedical.co.za
www.kznhealth.gov.za

Reference; HVK 04/05/2013
Enquiries: Ms N. Mngwengwe
Telephone: (033) 341 5626

04 June 2013

Mrs P D Joubert
Health Science Faculty
Department of Nursing
Durban University of Technology

Dear Mrs Joubert

RE: PERMISSION TO CONDUCT RESEARCH AT TOWN HILL HOSPITAL

The Town Hill Hospital Ethics and Research Committee convened a meeting on the 04 May 2013 to consider your application to conduct research at the institution.

The committee has no objection to this research being undertaken provided:

a. Appropriate permission from the Department of Health is obtained, with a copy thereof being provided to the hospital CEO.
b. A formal meeting with the Nursing Manager is arranged before the commencement of the study.

TOWN HILL HOSPITAL
P.O. BOX 400
2013 -06- 04
PIETERMARITZBURG 3200
CLINICAL DEPARTMENT

Yours faithfully

[redacted]

DR H V KING

Chairperson
Town Hill Hospital

[redacted]

MS Z G MFEKA
2013 -06- 06
CEO
Town Hill Hospital
HOSPITAL MANAGER

Appendix 5.5

The Chief Executive Officer: Mr. M. Green

The Nursing Service Manager: Mrs. N.C. Zondi

Umgeni Hospital

P/Bag X23 Howick

3290

18 April 2013

Request to conduct a Research Project

I am currently studying toward a Master of Nursing Degree at Durban University of Technology. I will request permission from the Health Research and Knowledge Management Committee to conduct a research project in health care facilities in KwaZulu-Natal. The facilities to be included in my study are in- patient mental health care facilities.

The purpose of this study is to investigate the roles of registered nurses and psychiatric nurses at in-patient psychiatric facilities, the primary challenges in caring for these patients and their educational preparedness to deal with this specialized area of nursing practice. The intention of this study is to enhance the quality of nursing care in mental health care facilities in KwaZulu-Natal.

Permission has been obtained from Durban University of Technology Departmental Research Committee, Faculty Research Committee and the Institutional Ethics and Research Committee: Ethical Clearance Number: IREC 026/13

Persons to Contact in the Event of Any Problems or Queries:

Researcher: Mrs. P.D.Joubert - Edendale Nursing Campus – 033 3456810

Email: perrenejoubert@yahoo.com

Supervisor: Dr. R. Bhagwan PhD (Community and Developmental Disciplines UKZN).

Durban University of Technology – 031 373 2197

Email:bhagwanr@dut.ac.za

Please contact the researcher, my supervisor or the Institutional Research Ethics administrator on 031 373 2900. Complaints can be reported to the DVC: TIP, Prof F. Otieno on 031 373 2382 or dvctip@dut.ac.za.

Sincerely

P.D.Joubert (Mrs)

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

UMGENI HOSPITAL, Old Main Road, HOWICK, 3290
Private Bag X 23, HOWICK, 3290
Tel.: 033 330 6146, Fax: 033 330 5564
Email: thuli.dladla@kznhealth.gov.za
www.kznhealth.gov.za

Enquiries: M.R. Green
Date: 02 May 2013

Mrs P.D. Joubert
Edendale Nursing Campus
uMgungundlovu Health District

CC. Mrs Zondi (Dep. Nursing Manager – Umgeni)

Dear Mrs Joubert,

Support for conducting of research at Umgeni Hospital

Please be advised that Umgeni Hospital is in support of the research proposal that you have submitted to the Department.

We are hoping that the findings will strengthen service delivery and the quality of client care in Psychiatric facilities.

Sincerely

[redacted]

Mr M Green
uMngeni Hospital: CEO (Acting)

Appendix 5.6

The Chief Executive Officer: Ms. G. L.L. Zuma

The Nursing Service Manager: Mr. B.C.Msibi

UMzimkhulu Hospital

P/Bag X 514

UMzimkhulu

3297

18 April 2013

Request to conduct a Research Project

I am currently studying toward a Master of Nursing Degree at Durban University of Technology. I will request permission from the Health Research and Knowledge Management Committee to conduct a research project in health care facilities in KwaZulu-Natal. The facilities to be included in my study are in- patient mental health care facilities. Numerous attempts to make telephonic contact with you have been unsuccessful. My intention was to inform you of my study telephonically, then follow up with electronic documents.

The purpose of this study is to investigate the roles of registered nurses and psychiatric nurses at in-patient psychiatric facilities, the primary challenges in caring for these patients and their educational preparedness to deal with this specialized area of nursing practice. The intention of this study is to enhance the quality of nursing care in mental health care facilities in KwaZulu-Natal.

Permission has been obtained from Durban University of Technology Departmental Research Committee, Faculty Research Committee and the Institutional Ethics and Research Committee: Ethical Clearance Number: IREC 026/13

Persons to Contact in the Event of Any Problems or Queries:

Researcher: Mrs. P.D.Joubert - Edendale Nursing Campus – 033 3456810

Email: perrenejoubert@yahoo.com

Supervisor: Dr. R. Bhagwan PhD (Community and Developmental Disciplines UKZN).

Durban University of Technology – 031 373 2197

Email:bhagwanr@dut.ac.za

Please contact the researcher, my supervisor or the Institutional Research Ethics administrator on 031 373 2900. Complaints can be reported to the DVC: TIP, Prof F. Otieno on 031 373 2382 or dvctip@dut.ac.za.

Sincerely P.D.Joubert (Mrs)

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Umzimkulu Psychiatric Hospital
Private Bag X 514, Umzimkulu 3297
Tel.039-2590310, Fax. 039-2590149
lindiwe.zuma@kznhealth.gov.za

Enquiries: Ms. PC Mjilo
Date: 18/04/2013
Ref :2/6/3

Mrs. P.D.Joubert

Edendale Nursing Campus – 033 3456810

RE: PERMISSION TO CONDUCT RESEARCH AT UMZIMKHULU HOSPITAL

I have pleasure in forming you that permission has been granted to you by the hospital management to conduct research " An investigation into the roles of psychiatric nurses and registered nurses at in-patient psychiatric facilities and its implications for nursing education in Kwa Zulu-Natal. "

Please note the following:

1. Please ensure that you adhere to all the 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 confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure that this office is informed before you commence your research.
4. The Facility will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the Sisonke District Research Committee and the District Management Team.

Thanking you.
Sincerely

[redacted]

MRS G.L.L. ZUMA
HOSPITAL CHIEF EXECUTIVE OFFICER

Appendix 6

Health Research and Knowledge Management

Secretariat

Private Bag X 9052

Pietermaritzburg

3201

24 May 2013

Dear Sir (Mr Xaba)

Request to conduct a Research Project

I am currently studying toward a Master of Nursing Degree at Durban University of Technology. I hereby request permission from the Health Research and Knowledge Management Committee to conduct a research project in health care facilities in KwaZulu-Natal. The facilities to be included in my study are in- patient mental health care facilities.

The following hospitals will be utilized in the study: Town Hill Hospital, Fort Napier Hospital, Umgeni Hospital, located in the UMgungundlovu Health District.
Ekuhlengeni Hospital, which is located in the EThekwini Health District.
Madadeni Hospital, which is located in the Amajuba Health District.
UMzimkhulu Hospital which is in the Sisonke Health District.
The purpose of this study is to investigate the roles of registered nurses and psychiatric nurses at in-patient psychiatric facilities, the primary challenges in caring for these patients and their educational preparedness to deal with this specialized area of nursing practice. The intention of this study is to enhance the quality of nursing care in mental health care facilities in KwaZulu-Natal.

Participation in the study is voluntary; all questionnaire responses will be anonymous. There will be no coercion of participants during the study. Permission has been obtained from Durban University of Technology Departmental Research Committee, Faculty Research Committee and the Institutional Ethics and Research Committee: Ethical Clearance Number: IREC 026/13

Persons to contact in the event of any problems or queries: Researcher: Mrs. P.D. Joubert Edendale Nursing Campus – 033 3456810 / 0843186269
Email:perrenejoubert@yahoo.com

Supervisor: Dr. R. Bhagwan PhD (Community and Developmental Disciplines UKZN). Durban University of Technology – 031 373 2197 Email:bhagwanr@dut.ac.za

Please contact the researcher, my supervisor or the Institutional Research Ethics administrator on 031 373 2900. Complaints can be reported to the DVC: TIP, Prof F. Otieno on 031 373 2382 or dvctip@dut.ac.za.

Sincerely P.D.Joubert (Mrs.)

Appendix 7

health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Health Research & Knowledge Management sub-component
10 – 103 Natalia Building, 330 Langalibalele Street
Private Bag x9051
Pietermaritzburg
3200
Tel.: 033 – 3953189
Fax.: 033 – 394 3782
Email.: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference : HRKM149 /13
Enquiries: Mrs G Khumalo
Telephone: 033 – 395 3189

07 June 2013

Dear Mrs P D Joubert

Subject: Approval of a Research Proposal

1. The research proposal titled **'An investigation into the roles of registered nurses and psychiatric nurses at in-patient psychiatric facilities and its implications for nursing education in KwaZulu-Natal'** was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby **approved** for research to be undertaken at Madadeni, Umngeni, Umzimkhulu, Fort Napier, Ekuhlengeni & Town Hill Hospitals.

2. You are requested to take note of the following:
   a. Make the necessary arrangement with the identified facility before commencing with your research project.
   b. 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 Mrs G Khumalo on 033-395 3189.

Yours Sincerely

[redacted]

Dr. E Lutge
Chairperson, KwaZulu-Natal Health Research Committee
Date: 07/06/2013

Appendix 8

DURBAN UNIVERSITY of TECHNOLOGY

Appendix 8

STATISTICIAN DECLARATION FOR CONSULTATION:

I, Deepak Singh have read Perrene Joubert's M.Tech proposal

(student no: 21237178) and given her appropriate recommendations.

Signed..... [redacted] ..... **Date 1 June 2012**