THE EXPERIENCES OF NON-PSYCHIATRIC TRAINED NURSES CARING FOR MENTAL HEALTH CARE USERS ON 72 HOUR OBSERVATIONS IN A LISTED HOSPITAL IN THE O.R. TAMBO DISTRICT.

by

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DEDICATION

This dissertation is dedicated to my late father, Winett and my mother, Nopelo Virginia Dubo who were such an inspiration to my philosophy of life. Their conviction that education is the best investment still shines in my mind and will be passed on to future generations.

DECLARATION

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ACKNOWLEDGEMENTS

ABSTRACT

Nurses are an integral part of the health care system and their job encompasses a wide range of responsibilities including the promotion of health, prevention of illness and care for physically, mentally ill and disabled people. Nurses have a mandate to be responsible and accountable to the public they serve. For these reasons, it is crucial that nurses possess attitudes that allow them to provide optimal care in a supportive manner for patients. Despite the fact that considerable research on the experiences of nurses caring for the mentally ill in general hospitals has been done globally, none has been conducted in the Eastern Cape, South Africa. Additionally, no studies could be obtained from anywhere in the world on the experiences of non-psychiatric trained nurses caring for mental health care users on 72 hour observations.

Studies indicated that nurses have different experiences when caring for mental health care users. It was therefore considered necessary to find out how non-psychiatric trained nurses perceive the caring of mental health care users during the 72 hour observations. The research design used to explore and describe their experiences was qualitative, descriptive, explorative, phenomenological and contextual in character. Semi-structured interviews were conducted with eight (8) participants who were purposively selected. This was done after necessary permission from the Department of Health and informed consent from the research participants.

Steps were taken throughout the course of the study to ensure trustworthiness. Data were analysed using Tesch's methods and the services of an independent coder were used. The results indicate that there are different experiences with regard to the caring for mental health care users during the 72 hour observations. The major themes identified are: feelings experienced by these nurses, lack of knowledge, challenges and strategies used for coping with a violent user, need for support from security staff and lack of policies.

Guidelines as a supportive action are suggested. From the results of the study recommendations are made in the areas of nursing education, nursing practice and nursing research. It is concluded that for non-psychiatric trained nurses to provide optimal care to mental health care users, the nurses need knowledge and skills in order to facilitate the promotion, maintenance and restoration of mental health of these patients as an integral part of health.

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CHAPTER 1

INTRODUCTION AND OUTLINE OF RESEARCH

1.1 BACKGROUND AND RATIONALE FOR THE STUDY

In South African hospitals, we have non-psychiatric trained nurses who find themselves caring for psychiatric patients during 72 hour observations. This study explored and described the experiences of non-psychiatric trained nurses caring for mental health care users on 72 hour observations. Being a professional nurse myself, I once worked in the Casualty/Emergency department and this was very stressful. This study helped in the formulation of guidelines to improve nurses' practice as well as to mobilize resources for the promotion, maintenance and restoration of mental health as an integral part of health. In this chapter, background of the study, significance, statement problem, purpose, objectives, research model, and research design will be discussed.

1.2 BACKGROUND OF STUDY

Mental Health Care Act no 17 of 2002 states that Mental Health Care User means a person receiving care, treatment and rehabilitation services or using a health service at a health establishment aimed at enhancing the mental health status of a user, state patient or individual incapable of taking decisions. Mental illness is a positive diagnosis of a mental health related illness in terms of accepted diagnostic criteria made by a mental health care practitioner authorized to make such diagnosis.

The combination of new medications for example chlorpromazine introduced in the early 1950s, and 'normalizing' people who were deemed mentally ill and closing down expensive establishments, all led to a radically different solution. No longer would the mentally ill have to be put behind large walls like during the Victorian period and its outdated hospitals. This development led to reasonable stable communities. Provided there was some sort of hospital backup and committed

community care, there was no need to resort to hospitalization even in cases of relapse (Turner & Salter 2008:8).

Williams and Mfoafo-M'carthy (2006:27) noticed that in the post de-institutionalization era, mental health care expectations were highly placed on families to provide care to all of their "sick" relatives. However, this commitment came with significant interpersonal and intrapersonal costs. Family members who commit to care-giving commonly experience disruption in relationships with each other and people outside the family. Walkins (2009:17) also noted that the problems faced by mental health care users were often more social than psychiatric. The difficulties had to do with being stigmatized, marginalized and impoverished. Poverty, unemployment, dislocated family and social networks, stigma, and discrimination all promote social exclusion and were both a cause and consequence of mental health problems.

According to Keltner, Bostrom and McGinennes (2011:8), homelessness was a problem that also influenced psychiatric care in the United States of America (USA). Vast numbers of individuals standing on streets with signs pleading for money are an example of this and studies have indicated that many of these people have a serious mental disorder. The effects of deinstitutionalization were also evident in emergency departments for example, emergency departments used by acutely disturbed individuals increased dramatically in the absence of the previous system. In some general hospitals, psychiatric units were overwhelmed at times with a continuous flow of patients. Around 1995, many professionals believed that the typical patients were different compared to patients of the 1960s and 1970. Patients of the 1990s to the present have been said to be more aggressive with many said to be armed when first seen in the emergency department (Keltener et al 2011:6). In the USA, Turner and Salter (2008:29) had similar findings, citing that large numbers of patients with mental illness were presenting via casualty departments. Casualty was increasingly becoming a place for prompt crisis intervention. The shortage of junior doctors was a serious problem and waiting times for several hours for assessments by a nurse were common. The attitude of casualty staff was slowly changing, possibly because the shift towards community based care was causing more cases to turn up in the

casualty department. Educational interventions in the form of lectures and seminars on the management of psychiatric emergencies became frequent.

According to Gold (2011:1) mentally ill patients in the USA often languish in hospital emergency rooms for several days before they can be moved to a psychiatric unit. At most, they get drugs but little counselling and the environment is often harsh. Staff does its best to care for mentally ill patients but it is the wrong place for someone in the midst of psychiatric crisis. In Britain and as stated by Williams and Mfoafo-M'carthy (2006:31) most of the clients were impressed about how they were managed by health professionals but some were not. For example one patient is cited saying, 'I didn't understand anything, I didn't feel anybody was there to help me".

Mental Health Act 17 of 2002 states that in South Africa, patients to be under 72 hour observation should be likely to inflict serious harm to himself or herself or others, that the user is incapable of making informed decision on the need for the Care, Treatment and Rehabilitation (CTR) and is unwilling to receive the CTR required.

During the 72 hour observation the medical practitioner should closely monitor the condition of the mental health care user and give a written report to the head of the health establishment concerned on such user's mental status at least 24 hours during the 72 hour assessment period. The 72 hours should commence at a general hospital which may be followed by a decision for further involuntary care at a psychiatric hospital. The patient is assessed to exclude underlying medical illness and to provide treatment so that the patient gains insight and good judgment and can consent to further management. It is important to understand nurse's experiences towards the mentally ill and possible factors which might have led to the formation of these experiences. It is likely that a person's background and experience may influence his/her attitude towards mentally ill patients.

In California, a 72 hour mental evaluation also known as "5150" is performed by detaining a person who is dangerous to himself or others, seriously disabled or seriously mentally ill for a period of 72 hours for evaluation purposes. The "5150" is

so named because this procedure is for an involuntary psychiatric hold outlined in section 5150 of the California Welfare and Institutions Code (Mental Health Association of California.2014).

Mental Health Care Act 17 OF 2002 states that mental health care user must be given appropriate care, treatment and rehabilitation services and these services are rendered by nursing and medical team.

A nurse is someone who is educated in the scientific basis of nursing under defined standards of education and is concerned with the diagnoses and treatment of human responses to actual or potential health problems. According to Stedman's dictionary (2012:1174), nurses are an integral part of health care system. Their job encompasses the promotion of health, prevention of illnesses and care for physically ill, mentally ill and disabled people. Nurses have a mandate to be responsible and accountable to the public it serves and are expected to deliver care to patients utilizing the nursing process of assessment, planning, intervention, implementation, and evaluation. For these reasons, it is crucial that nurses possess attitudes towards the mentally ill that allow them to provide optimal care in a supportive manner for these patients (Woodbridge-Dodd 2012:508).

According to Cresia and Parker (2005:14) nurses are trained in hospital colleges of nursing up to institutions of higher learning. In this study, nurses were found to have different training backgrounds and it has been noted by Ross and Goldner (2009:558) that there is considerable evidence that the subspecialty of psychiatry is devalued within the nursing profession. In South Africa there are four categories of nurses according to the qualifications framework currently in use: (1) enrolled nursing auxiliaries (ENA) who train for 1 year, (2) enrolled nurses (EN) who train for two years, (3) registered nurse/ midwife (RN/M) who train for 4 years and, (4) specialist registered nurse/midwife. According to statistics of South African Nursing Council (SANC) of 2010, South Africa had a ratio of 3:2:1:4 for ENA: EN: RN/M: SRN/M (Uys & Klopper 2013:1).

1.3 SIGNIFICANCE OF THE STUDY

The literature review showed that no study of this nature had been done in the Eastern Cape. By exploring and describing the experiences of non-psychiatric trained in caring for mental health care users on 72 hour observation in a Casualty/Emergency Department of this listed hospital, it was hoped that the findings would contribute further to nursing knowledge which will in turn help in the formulation of guidelines that would support nurses in the management of these patients. The study was also prompted by various beliefs about the mentally ill held by nurses and the public in general in the Eastern Cape. This study helped to clarify some aspects, both positive and negative, in the department of health regarding nursing and mental illness.

1.4 THE STATEMENT OF THE PROBLEM

The need for care for people with mental health problems in general hospitals has increased. Nurses are the major providers of hospital care and have become an important resource in the delivery of mental health care. However, the attitudes and abilities of many nurses in providing this care has been shown to be poor (Frances & Les 2005:249). Gillian (2010:167) makes the same observation that nurses working in the general hospital setting lack the knowledge and skills necessary to assess and manage patients with mental health problems.

Since 2010, when the researcher was placed in the Casualty/Emergency Department of the hospital where this study was conducted, he observed that most of the untrained nurses had negative attitudes towards mentally ill patients. For example, one family known to the researcher got upset because a non-psychiatric trained nurse sedated the patient in question and proceeded to chase the patient out of the Emergency Room saying that the patient was noisy. On top of that, the nurse did not professionally explain to the family what was to follow after sedation. Some nurses in a similar position constantly complained about the mixing of 72 hour observation patients with medical patients in the Casualty/Emergency Department. The challenges included that nurses were expected to care for every admitted

patient to this Department resulting in some of the mentally ill patients absconding or getting lost in the absence of relatives to look after them.

The following research questions arose:

1. What are the experiences of Casualty/Emergency non-psychiatric trained nurses towards mental health care users during the 72 hour observation?
2. What guidelines can be formulated to improve their psychiatric nursing skills to mobilize resources to facilitate the promotion, maintenance and restoration of mental health as an integral part of health?

1.5 THE PURPOSE OF THE STUDY

The purpose of the study encompasses the aims or goals the investigator hoped to achieve and not the problem to be solved (Geri-Lobiondo-Wood & Haber 2010:60). The purpose establishes the general direction of inquiry (Houser 2012:90), and the purpose of this study was two-fold:

- Exploration and description of the experiences of non-psychiatric trained nurses in caring for mental health care users on 72 hour observation.
- Describing the guidelines that can be formulated in order to improve the psychiatric nursing practice of these nurses to mobilize resources in facilitating the promotion, maintenance and restoration of mental health as an integral part of health.

1.6 OBJECTIVES OF THE STUDY

Polit and Beck (2008:568) describe objective as a specific accomplishment the researcher hopes to achieve by conducting a study. The objectives include answering research questions but may also broaden some aims, for example, developing recommendations for changes in nursing practice based on study results. The objectives of this study were two-fold:

1. To describe experiences of non-psychiatric trained nurses in caring for mental health care users on 72 hour observations.

2. To describe the guidelines that can be formulated in order to assist the practice of these nurses.

1.7 RESEARCH MODEL

The process of research was based on a model of research in nursing proposed by Botes (2006:9). According to this model, nursing activities take place at three interrelated orders. In the first order, the activities are concerned with nursing practice. It is during the nursing practice that research problems can be identified and where research findings can be validated. In this study, the researcher was interested in the nursing practice and experiences of non-psychiatric trained nurses in caring for mental health care users on 72 hour observations in the Casualty/Emergency Department of a listed hospital in the Eastern Cape.

In the second order, nursing activities are concerned with research and theory generation, hence development of nursing knowledge. The practitioner in turn is responsible for applying the knowledge which is generated by research and theory formulation to practice in order to confirm the usefulness thereof. By exploring and describing the experiences of non-psychiatric trained nurses towards the mental health care users on 72 hour observation in a Casualty/Emergency Department of a listed hospital, it was hoped that the findings would contribute further to nursing knowledge which will in turn help in the formulation of guidelines that would support nurses in the management of these patients.

In the third order: the model is concerned with the paradigmatic perspective. The researcher has to declare his assumptions which are meta-theoretical, theoretical and methodological in nature. These assumptions will be discussed in the following section.

1.8 PARADIGMATIC PERSPECTIVE

In approaching this study, the researcher acknowledges the complexity of the research phenomenon and believes that holistic approach is especially suitable for studying a phenomenon such as the experience of nurses. To this end, the

assumptions of the Theory for Health Promotion in Nursing (University of Johannesburg, School of Nursing 2006:2) was utilized. According to this theory, the following assumptions can be stated:

1.8.1 Meta-theoretical assumptions

- **PERSON**

The whole person embodies dimensions of body, mind and spirit. The person functions in an integrated, interactive manner with the environment. Person refers to nurses. They are all spiritual beings functioning in an integrated bio-psychosocial manner to achieve their quest for wholeness. Because they interact holistically with their internal and external environments, their experiences are unique.

- **NURSING**

Nursing is an interactive process where the nurse as a sensitive therapeutic professional facilitates the promotion of health through the mobilization of resources.

- **HEALTH**

Health is a dynamic interactive process in the patient's environment. These interactions in the person's environment reflect the health status of the patient. The interactions contribute to or interfere with the promotion of health. In this study, mental health is the focus. Health and wholeness are used synonymously. Mental health is an integral part of wholeness. Wholeness and health is a state of spiritual, mental and physical wellness. The experiences of these nurses together with their internal and external environment determine their health status. In this study it is accepted that caring for the mental health care user that you are not trained to care for can be regarded as a factor in the external environment of the nurses.

- **ENVIRONMENT**

Environment encompasses both the internal and external environment. The environment of the nurse is multidimensional. The internal environment comprises the body, mind and spirit, while the external environment comprises physical, social and spiritual dimensions (Theory for the Health promotion in nursing 2006:5).

- **PROMOTION OF HEALTH**

Heath promotion includes the promotion, maintenance and restoration of health and is aimed at the facilitation of an individual, family, group and community's mobilization of resources.

1.8.2 Theoretical assumptions
The following are the theoretical assumptions guiding this study.

- **NURSING THEORY**

The underlying nursing theory in this study was the Theory for Health Promotion in Nursing by Botes (2006:4).

The researcher bracketed all his preconceived ideas and went to the field with an open mind. After conducting the interviews the results were decontextualized into the literature.

a). Theoretical definitions

- **INDIVIDUAL**

An individual is a whole person who embodies dimensions of body, mind and spirit. The individual functions in an integrated, interactive manner with the environment.

- **FAMILY**

The family is the basic unit of society composed of individuals mutually valued and interacting.

- **GROUP/COMMUNITY**

A group/community is an identifiable group of persons who share a common interactive pattern and / or geographical location.

- **PSYCHIATRIC NURSING**

This is a culture-sensitive interactional process between a psychiatric nurse and a patient, concerned with the provision of a comprehensive mental health service (promotion, maintenance and restoration).

Maintenance of health refers to nursing activities that are directed towards promoting and preserving the health status of the patient. Promotion of health refers to nursing activities that contribute to a greater degree of wholeness in the patient. Restoration of health refers to nursing activities that facilitate the return to the previous experiences of the patient.

- **PHYSICAL**

This refers to the physical and chemical agents/ structures in the external environment of the individual /family/ group/community.

- **INTELLECT**

This refers to the capacity and the quality of the psychological processes, thinking, association, analysis, judgment and understanding of which the individual /family/group/community are capable.

- **EMOTION**

Emotion is a complex state which can be divided into affection, desire and feelings of the individual/ family/ group/ community.

- **PSYCHE (soul)**

The psyche includes all the intellectual, emotional and volitional processes of the individual/ family/ group/community.

- **VOLITION**

Volition is a process of decision making in the execution of a choice by the individual/family/group/community.

b). OTHER DEFINTIONS

- **Experience**

Stedman's Medical Dictionary (2012:1269) describes experience as the knowledge and skill that you have gained through doing something for a period of time.

- **Guideline**

A rule or directive outlining a policy or procedure (Stedman's Dictionary 2012:728).

- **Casualty/Emergency Unit**

Unit for those who require temporary treatment for simple diseases or injuries (Wadrope and Sakr 2000:314).

- **Psychiatric Nurse**

This refers to a professional person who is educated to interact with a patient in a goal-directed way in assisting him/her to mobilize his/her resources to facilitate his/her quest for mental health as an integral part of health and must be registered with the South African Nursing Council.

In this study the non-psychiatric trained nurse refers to general professional nurse (bridging) and enrolled nurse (staff nurse) not trained in how to interact with a mental case and yet are accountable for their actions during the caring of these patients.

- **Bridging Course for Enrolled Nurse to Register as Professional Nurse**

This is a regulation of the Nursing Act, 1978 (Act 50 of 1978) and any expression to which a meaning has been assigned in the Act with a period of 44 weeks in any calendar.

1.8.2 Methodological assumptions

The methodological assumptions guiding this study were in line with the research model developed by Botes (2006:1) – a functional approach in nursing. In other words, nursing research should address current health problems experienced by the South African community and should proffer solutions. In this research, data gathered from interviews with non-psychiatric trained nurses caring for mental health care users was used to formulate guidelines to assist in the practice of these nurses. This achieved the functionality of the research.

1.9 Central statement

The exploration and description of the experiences of non-psychiatric trained nurses caring for mental health care users on 72 hour observation provided the basis for generating guidelines that were formulated in order to assist in the practice of these nurses to promote, maintain and restore mental health as an integral part of health. The test of validity of the study is in its functionality.

1.10 RESEARCH DESIGN

The design used in this study follows the research model of nursing outlined by Botes (2006). Botes (2006) states that the activities of the discipline of nursing take place at three levels or orders which are interrelated and influence one another. This model demands that the researcher pay attention to the determinants of research from initiation, conceptualization, formulation, research design through to implementation. The determinants of research are: characteristics of research domain, assumptions of the researcher, research context and the research objectives.

1.11 CHAPTER SEQUENCE

CHAPTER 1: INTRODUCTION AND OUTLINE OF RESEARCH

CHAPTER 2: LITERATURE REVIEW

CHAPTER 3: RESEARCH DESIGN AND METHODS

CHAPTER 4: RESULTS

CHAPTER 5: DISCUSSIONS, GUIDELINES, RECOMMENDATIONS, LIMITATIONS AND CONCLUSION

1.12   CONCLUSION

As there are various beliefs about the mental health care users, this study has clarified some aspects that are positive and negative for the Department of Health

and the nursing profession (in the psychiatry discipline), therefore improving the psychiatric nursing practice, whilst at the same time contributing to the body of knowledge that is already available in the nursing field.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

The purpose of this chapter is to review related and relevant literature concerning the topic under investigation to contextualize and clarify the researcher's concern with the experiences of non-psychiatric nurses caring for mental health care users on 72 hour observation in the Casualty/Emergency Department. The review endeavoured to cover what has been done in the field of study, the gaps that still exist, the contracting view points, and what still needs to be done. Brink (2012:60) states that literature review involves finding, reading, understanding and forming conclusions about the published research subject and theory as well as presenting all these in an organized manner.

According to Houser (2012:107) literature review is a critical component of the research process that provides an in-depth analysis of recent findings in specifically identified areas of interest. Today's nursing professionals must function in an atmosphere that produces best practices when rendering patient care. To provide for best practice, researchers must build a foundation of the best evidence-proof of what is and not known on a topic of investigation. Once the challenge of identifying the research problem has been resolved, the researcher needs to ascertain the knowledge that has been established. Sources for this evidence comes from primary and secondary literature resources. Furthermore, nursing activities reflect "an interdependent relationship between practice, theory and philosophy " (Botes, 2006:6) for the discipline. The purpose of literature review in this study was to facilitate the process of data analysis, interpretation of research findings and making appropriate recommendations.

Brink, van de Walt and van Rensburg (2012: 71) state that the researcher conducts the literature review for various reasons:

- To conduct a critical analytical appraisal of recent scholarly work on a topic. By determining what is already known about the topic, the researcher can obtain a comprehensive picture of the stage of knowledge.
- To identify the research problem and refine the research questions.
- To place the study in the context of the general body of knowledge, which minimizes the possibility of unintentional duplication and increases the probability that the new study will make a valuable contribution.
- To obtain clues to the methodology and research instruments. This aspect provides the researcher with information on what has and has not been attempted with regard to approaches and methods, and on what types of data collection instruments exist and work or do not work.
- To refine certain parts of the study, specifically the problem statement, hypothesis, conceptual framework, design and data-analysis process.
- To compare the findings of existing studies with those of the study at hand. This process shows the relevance of the latter findings to the existing body of knowledge.
- To inform or support a qualitative study, especially in conjunction with the collection and analysis of data.

The following concepts were of interest to the researcher:

A. Casualty.

B. Mental health Act.

C. Mental illness.

D. Mental health care user.

E. Nursing Practice.

F. Psychiatric theory.

2.2 CASUALTY

According to Wardrope and Sakr (2000:314) the original term for casualty meant a seriously injured patient. It was predominantly a military word, a general term for the accidents of service: after a battle the dead, the wounded and the sick lumped together as "casualties". The term "casual" has its origin from the work-house "casual" who was one of the unemployable permanents, but the irregular and unexpected caller who needed temporary help. The casualty department services those who require treatment for simple diseases or injuries. Matthias and Hoff (2012:498) further describe casualty/emergency department as a medical treatment facility for specializing in acute care of patients who present without a prior appointment either by the own or by that of an ambulance and due to unplanned nature of patient attendance, the department must provide initial treatment for a broad spectrum of illnesses.

2.3   MENTAL HEALTH CARE ACT

This is an act which is meant to provide care, treatment, and rehabilitation of persons who are mentally ill, to set out different procedures to be followed in the admission of such persons, to establish Review Boards in respect of every health establishment, to determine their powers and functions, to provide for the care laws, and to provide for matters connected therewith.

2.3.1 Historical perspective

South Africa was lauded in 1994 for peacefully dismantling the shackles of an apartheid system that discriminated against people on the basis of race. Ten years later, in 2004, the new democracy promulgated the Mental Health Care Act 17 of 2002 (MHCA) which sought to dismantle the apartheid practices that existed within a health care system that discriminated against those with mental illness. The resulting intervention was that that every patient should be subjected to 72 hour assessment (Ramall 2012:407). According to MHCA of 2002 a patient who should be under 72 hour observation is one likely to inflict serious harm to himself or herself or others; a user incapable of making an informed decision on the need for CTR (Care,

Treatment and Rehabilitation) and is unwilling to receive the CTR required and requires protection of his/her financial interests and reputation.

During the 72 hour observation, the medical practitioner is expected to closely monitor the condition of the mental health care user and give a written report to the head of the health establishment concerned on such user's mental status in at least 24 hours during the 72 hour assessment period. This 72 hours should commence at a general hospital which may be followed by a decision for further involuntary care at a psychiatric hospital. The patient is assessed to exclude underlying medical illness and to provide treatment so that the patient gains insight and good judgment and can consent to further management. The Mental Health Care Act states that when a person is lacking insight and good judgment, such a person is said to have a mental illness and can cause significant distress and potential danger to the family, community and to him or herself. This principle is also applied in California. As stated by the Mental Health Association of California, "5150" can only be carried out when the person is a danger to himself or others, when he is truly in danger of hurting himself, harming another person or is gravely disabled and unable to provide food or shelter for himself. The hospitalized mental health care user may not leave the hospital on his/her own accord and must be held for 72 hour observations and possible treatment. The hospital does not have to hold a patient if it finds that after the evaluation he is of no danger to himself or others and is not gravely disabled.

2.3.2 Challenges of 72 hour observation

Challenges have been noted regarding patients on 72 hour observation when patients with medical illnesses are involuntarily admitted under the MHCA, subjected to very restrictive care (restraints and sedation) and occasionally transferred to psychiatric units early because of resource constraints, stigma and long term consequences. Proposed amendment to the MHCA is that the involuntary 72 hour assessment be separated from an involuntary admission, it should follow a 72 hour assessment with all the relevant forms.

Ludwig, Pande and Alakeson (2010:1637) state that because emergency rooms are poorly equipped to deal with mental health needs, boarded patients do not receive

high-quality care there. Pharma and Healthcare (2014:1) hold the same view and point out that about 84 per cent of emergency physicians report that patients are 'boarded' in the emergency department and Gold (2011:1) adds that during this stay they get drugs but little counselling and the environment is often harsh This situation tends to lead to violent behaviour by distressed psychiatric patients, distracted staff and bed shortages and this in turn can lead to biased treatment of patients. According to Newell (2009: 46) it has been noted that for a long time people have been discriminated because of their disability, 'race', ethnicity. There was a new legislation in the United Kingdom aimed at tackling discrimination based on disability, 'race', and gender. The Race Relations (Amendment) Act 2000 came into force in April 2001 and one such commitment was to provide protection to individuals experiencing discrimination on the grounds of colour, nationality or national origin. The Act protects individuals from discrimination in accessing services (including health services) and facilities by promoting equity to accessible and fair services.

2.4 MENTAL ILLNESS

According to Varcolis and Halter (2009:4), mental illness refers to all mental disorders with definable diagnoses. Thinking may be impaired as in Alzheimer's disease, mood may be affected as in major depression and behaviour alterations may be apparent in schizophrenia or the patient may display some combination of the three. In the past, the term mental illness was applied to behaviours considered to be 'strange' and 'different' that would occur infrequently and deviating from an established norm. Mental illness is also considered to be a clinically significant behavioural or psychological syndrome marked by the patient's distress, disability or the risk of suffering disability or loss of freedom.

2.4.1 Historical perspective

Mental Health was controlled by the Mental Health Act 17 OF 2002 which was modified from time to time. The objective of the Act was to treat, care and control. Emphasis was more on control. Protection of the public was embedded in practices which included seclusion of the mentally ill in single rooms to control unacceptable

behavior, use of mechanical restraints and strait jackets for destructive and violent episodes, as well as large doses of tranquillizers. Large wards were used to accommodate patients. Locked doors prevented patients from visiting other wards. Carers were supplied with whistles and keys to enable them to call for help if there was violence. There were very few trained "mental nurses" supported by a high percentage of untrained carers who acted as rehabilitation staff in the wards by training patients on maintenance of personal hygiene, cleaning wards, bathing, dishing food and washing dishes after meals. Non-violent patients worked at the laundry to sort dirty linen and pack clean linen. All hospitals had farms on which vegetables were produced by patients and employees for feeding patients and also for sale on the open market. This enabled some patients to acquire different skills although there was no policy on rehabilitation. Mental health care was provided in mental hospitals divided according to racial groups, all of them closer to cities. Whites had rehabilitation and community services not open to other races. Family contact of most black patients was not frequent and at times not possible because these hospitals were from rural communities far from where patients lived. Long-term patients lost contact with their relatives and developed institutionalization. The lives of most patients were centred on the routine domestic work they performed. Recreation was in the form of walks within the hospital premises, sport for a few patients and staff, music and dance for those whose orientations had improved.

The Mental Health Care Act 17 OF 2002 describes mental illness as positive diagnosis of a mental health related illness in terms of accepted diagnostic criteria made by a mental health care practitioner authorized to make such diagnosis. Butler and Pritchard (1983:6) view mental illness as an act which implies that the person has had a period of normality before she/he becomes mentally ill, and it represents some kind of change in otherwise normally developed or developing person. This view is also shared by Sweeney and Horwitz (2001:10) who cite marital disruption as one cause of depression where the mood will be affected after a normal behaviour. These authors are of the opinion that divorce is associated with numerous psychological conditions and indeed may be among the most stressful events that an individual may experience.

Furthermore, Pilgrim (2005:28) argues that the amount and particular types of stress experienced by women result in a higher rate of female psychiatric morbidity. According to Pilgrim (2005:28), two aspects of women's societal roles explain why women experience more psychological distress than men. Firstly, women's roles (which tend to be domestic) make them more vulnerable to mental distress because they have time to brood about their problems. Secondly, there is evidence that poorer mental health is found in situations where women are more likely to occupy nurturing roles (e.g. divorced single women who care for children have a higher incidence of mental distress than divorced women without children). Additional factors include that can increase one's risk of developing mental health problems include financial problems, being abused or neglected as a child and this can begin at any age from childhood through to later adulthood (http//www.apa.org/helpcenter/understanding).

According to Sokhela (2014:7) however, mental illness is a temperament with which a person is born and becomes a personality over time. These personality traits become a disorder if they impact and become a problem for the people around and affect the individual's cognitive, social and occupational functioning. Many people do not seek medical help for fear of being labelled 'crazy' or because they are not aware that they are ill and as such Fennel (2007:1) defines mental illness as any disorder or disability of the mind.

Following Weiss and Lonnquist (2000:18), among the commonly used categories of mental disorders are:

- Anxiety disorder including phobias, panic disorder and obsessive-compulsive disorder;
- Affective disorders including depression;
- Schizophrenia;
- Antisocial personality disorder;
- Bipolar disorders, and
- Mental retardation and profound learning disability.

2.4.2 STIGMATIZATION

As stated by Kriste and Leech (2006:68) stigmatization is a process of labelling or the process that appears to justify being labelled or branded or singled out. Regardless of diagnoses of the mental health care user, any kind of mental illness has profound social implications for both the afflicted individual and his/her family. The course and outcome of mental illness are hampered by stigma and discrimination. The stigmatization of mental illness makes it difficult for those affected to cope and readily accept the condition. Consequently, families tend to isolate the afflicted (Butler & Pritchard 1983:36).The stigma of mental illness makes it very difficult for the family and significant others to cope with the patient. The family and the patient might feel confused, distressed and depressed. Therefore the family's involvement in the caring activities of the mental health care user is crucial.

Ngqoboka, Gmeiner and Poggenpoel (1999:42) cites families who report that when the mentally ill are discharged they are unmanageable resulting in the discontinuation of medication because there are no nearby clinics and lack of money for public transport. The end result is that many patients relapse and have to be re-admitted in the hospital. Public attitudes towards mental health care users is important for proper community care and self-esteem of the afflicted individual. The role of the public should be to harness the resources of the family. Link and Phelan (2004:68) identify the following process of exclusion for people with mental illness. Firstly, such a person is labelled in the context of mental illness. Such a label is related to negative attributes and this implies a stereotyping of the person as dangerous or incompetent. Finally the labelled person 'becomes the label', so that they change, for example, from being a person with schizophrenia to the disease itself (Lester & Glasby 2006:86).

Mental health care users tend to have a smaller social network with many of their contacts related to health care services rather than to sports, family, faith, employment education or art and culture. One survey found that 40 per cent of mental health care users have no social contact outside mental health care as fear for stigma and discrimination can lead to severe loss of confidence (Ford, Beadsmore, Norton, Cooke & Repper 1993:409).

2.5 NURSING PRACTICE

According to Sokhela (2014:7) care for mental health care users in South Africa has developed from social care to more therapeutic approaches over many years. Custodial care led to institutionalization and "criminalization" of mental health care users and this has been noted in America. Custodial care has brought about some challenges even for developed countries like America. Boarding psychiatric patients' results in scarce emergency rooms and resources, further prolonging the amount of time that all patients must spend waiting for final diagnosis. This is the result of the inability of community-based care (Alakeson, Pande & Ludwig, and 2009:1637).

Stedman's Dictionary (2012:1174) states that nurses are an integral part of the health care system and their job encompasses a wide range of responsibilities including the promotion of health, prevention of illnesses and care for the physically ill, mentally ill and disabled people. Nurses have a mandate to be responsible and accountable to the public they serve. For these reasons, it is crucial that nurses possess attitudes towards the mentally ill that allow them to provide optimal care in a supportive manner for these patients.

According to Mavundla (1993:28) in Durban, about 90 percent of nurses in general wards harbor negative attitudes whilst 10 percent possess positive attitudes towards the mentally ill. Mavundla's (1993) also revealed that there was an intra-institutional relationship problem between non-psychiatric and psychiatric staff. It also became clear that nurses' experiences of violence when attending mentally ill people within a general hospital setting was negative and affected their social and psychological functioning. When Mavundla's (1993) study was conducted there was no 72 hour observation and therefore this study will be on patients that are on 72 hour observation in the Casualty /Emergency Department and insights from the study should help inform the practices of nurses in that department. Furthermore, according to Mavundla, Poggenpoel and Gmeiner (2000:38) in Kwazulu Natal the professional nurses experienced fear, physical violence, and need for support from security staff when nursing the mental health care users. This finding was similar to findings in America (Zolnierek and Clingerman 2012:229).

According to Kathy (1996: 34) nurses in Columbia who had an average psychiatric nursing experience of less than 13 years with no further in-service or educational training on care of mentally ill patients, had positive experiences of caring for individuals diagnosed with a mental illness. This stands in contrast with the findings of Rankhumise, Netswera and Lethoba (2006:8) who found that about 60 percent of nurses in Gauteng with above 11 years' experience in casualty were able to establish relationship with a mental health care user regardless of the fact that these nurses lacked formal training knowledge.

In the United States as stated by Harms (2010:59) nurses who are not psychiatric trained believed themselves to be open-minded and empathetic. The same study also found that there was a dissonance between how the nurses hoped to be and how they actually felt. Most also indicated a perceived lack of skills in working with this population. This contrasted the findings by Morris, Scott, Cocoman and Clinton (2012:460) that nurses in Ireland had negative attitudes towards people with mental illness. Understandably, this situation had serious implications for the care and recovery of Irish patients who required a positive, supportive and caring environment. Suokas, Suominen and Lonnqvist (2009:131) arrived at the same conclusion about non-psychiatric trained nurses. According to Aydin, Yigit, Inandi and Kirpinar (2015:22) in some contexts, the attitudes of nurses toward the mentally ill subjects were generally negative, even when the respondents had been educated about "facts" of mental illness.

Rankhumise,Netswera and Lethoba (2006:4) state that in Gauteng, professional nurses had a predominantly positive perception of self in caring for the mentally ill in a general hospital setting although some had negative attitudes owing to lack of knowledge and skills. Nurses in Australia as stated by Fitzgerald and Reed (2005:251) exhibited negative attitudes towards mental cases and claimed that caring for the mentally ill was not their role because of fear and lack of training. However, according to Sharrock and Happell (2006:13) non-psychiatric trained nurses in Canada had positive attitudes towards people with mental health problems and acknowledged mental health care as of their nursing work.

2.5.1 Challenges of the nursing practice during the 72 hour observations

In Cape Town, South Africa, a problem of infrastructure and specialist personnel for providing the 72 hour emergency management and observations in general hospitals was mentioned recently (online: www. news24.com. Accessed 19 May 2015). Nurses in Italy, in a study by Palese, Santor, Costaperaria and Bresadola (2009:185) complained of interruptions in casualty, including telephone calls and giving of medication during the 72 hour observation, to a point that they suggested a creation of a calm atmosphere by creation of a dedicated ward. In Port Elizabeth, according to Gonzalez (2013:3), health care workers also reported that facilities in the area battled shortage of drugs. Through a comparative study by Yan (2012:2) psychiatrists concluded that drug shortages were not restricted to developing countries only because countries such as America and Canada were said to experience the same.

2.6 PSYCHIATRIC THEORY

Most current graduates working in the emergency department are professional nurses drawing on their limited undergraduate health experience (Clinton and Hazelton, 2005:2). Some graduate programs in West Africa offer a six month rotation in mental health nursing. However, Australian nursing workforce studies reported that few nurses take this option and according to Crowley (2006:2) this is due to the perception that mental health nursing is not a caring or satisfying. The cause of this attitude was cited as fear and anxiety deriving from lack of knowledge. According to Kerrison and Chapman (2007:48) nurses considered the assessment and management of patients with acute mental health problems to be inadequate and this was due to lack of knowledge and skills and was compounded by a lack of education and training in this area.

2.7 CONCLUSION

From this literature, it is clear that non-psychiatric trained nurses have different experiences when caring for mental health care users. Furthermore it also show that no study of this nature had been done in the Eastern Cape. It also clarify some

aspects regarding the nursing practice and some suggestions that can help to improve the nursing practice.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

In chapter one of this study an outline and paradigmatic basis of this research was given. In this chapter, the research design and method used in conducting this study will be described. Included is the description of research design, methods, population and sample, the discussion of data collection and data analysis procedures. The chapter also discusses how measures for ensuring trustworthiness were applied.

3.2 RESEARCH DESIGN

According to Polit and Beck (2008:765) research design Research is the overall process of implementing the research study, including who was included in the study, how information was collected and what interventions, if any, were tested. Burns & Grove (2011:570) view research design as a blue print for conducting a study. It is the overall plan for acquiring new knowledge or confirming existing knowledge. It can also be viewed as the plan for systemic collection of information in a manner that assures that the answer (s) found will be as meaningful and accurate as possible. According to Wood and Ross-Kerr (2011:2) research is done with the purpose to answering questions, whether they arise from a practical need or simple curiosity.

The research design used in this study was qualitative, phenomenological, descriptive, explorative and contextual. Each of these designs will be described with the following sub-headings:

3.2.1 QUALITATIVE DESIGN

The purpose of qualitative research is to understand a particular social situation, event, role, group or interaction. It is largely an investigative process whereby the researcher gradually makes sense of social phenomenon by contrasting, comparing, replication, cataloguing and classifying the objective of the study (Creswell

2014:116). Qualitative research occurs in natural settings, where human behavior and events occur and the researcher is the primary instrument in data collection.

This study is concerned with exploring the experiences of non-psychiatric trained nurses caring for mental health care users. According to Burns and Grove (2011:73) qualitative design is a systematic, subjective approach used to describe life experiences and give them meaning. Wood and Judith (2010:29) observe that qualitative design is gaining recognition as a sound method for investigating complex human phenomena compared to quantitative design.

Brink (2008:113) states that the qualitative approach is more appropriate and effective especially when one wishes to explore the meaning or describe and promote understanding of human experiences. Qualitative methods focus on the qualitative aspects of meaning, experience and understanding and study human experience from the view point of the research participants in the context in which the action takes place. A qualitative design was therefore, suitable for this study which investigated "how people make sense of their lives, experiences, and their structures of the world" (Creswell 2014:145).

3.2.2 PHENOMENOLOGY

Phenomenology studies the human experience through descriptions that are provided by the people involved. The experiences of respondents are called 'lived experiences'. The purpose here is to describe what people experience in regard to certain phenomena as well as how they interpret the experiences or what meaning the experiences hold for them. Therefore, phenomenology is an approach that concentrates on a subject's experience rather than on the person as a subject. The researcher focuses on what is happening in the life of the individual, what is important about the experience and what alterations can be done. Data emerging from this research study is phenomenological, as the participants were asked about their experiences towards caring for mental health care users. From the analysis of data, guidelines have been formulated in order to help in the practice of nurses in a similar situation (Brink 2008:114).

3.2.3 DESCRIPTIVE DESIGN

Polit and Beck (2010:552) describe descriptive design as a research that has its main objective as the accurate portrayal of the characteristics of persons, situations or groups and/or the frequency with which certain phenomena occur. No matter what method is chosen to collect the data, all descriptive designs have one thing in common: they must provide descriptions of the variables to answer the question. The type of description that results from the design depends on how much information the researcher had about the topic prior to data collection. Wood and Ross-Kerr (2011:121) state that descriptive design examines one or more characteristics of a specific population. Descriptive studies do not have the degree of flexibility found in explorative designs.

Descriptive studies are designed to gain some information about characteristics within a particular field of study (Burns & Grove 2001:295) and this study was conducted in the nursing profession. Descriptive studies are conducted when one wants to provide an accurate portrayal of a phenomenon as a means of discovering new meanings (Burns & Grove 2001:29) and in this study the experiences of non-psychiatric trained nurses are described after the participants were asked the same question so as to give a clear description, interpretation and explicit statement of the problem. In this study the descriptive design was used to:

- Describe the experiences of non-psychiatric trained nurses caring for the mental health care users on 72 hour observation.
- Describe the guidelines that would be formulated to improve the practice of these nurses in order to mobilize resources to facilitate the promotion, maintenance and restoration of mental health as an integral part of health.

3.2.4 EXPLORATIVE DESIGN

The design was aimed at exploring the experiences of non-psychiatric trained nurses in relation to caring for mental health care users. Explorative design provides an in-depth exploration of a single process, variable or concept. Wood and Ross-Kerr (2011:121) state that when the purpose of a study is exploration, a flexible design that provides an opportunity to examine all aspects of the problem is needed.

The word 'exploratory' indicates that not much is known, which means that the survey of the literature failed to reveal any significant research in the area. Thus, one cannot build on the work of others and must explore the topic for him/herself. It is an initial step in the development of new knowledge. In this case, exploring the experiences of non-psychiatric trained nurses will assist in gaining new insights into the phenomenon. Since it was an exploratory design, the researcher strived to ensure that all opportunities to examine various aspects of the problem were exhausted.

3.2.5 CONTEXTUAL DESIGN

The research topic lends itself to a contextual approach. The contextual approach is uniquely descriptive in that differences and distinguishing characteristics are described (Botes 2006:5). The researcher was set to explore and describe the experiences of non-psychiatric trained nurses caring for the mental health care users on 72 hour observations and provide guidelines that would be formulated to facilitate, maintain and restore mental health as an integral part of health. Data was collected from the non-psychiatric trained nurses within the casualty/emergency department where these nurses worked.

3.3. RESEARCH METHODS

Polit and Beck (2012:741) describe research method as the technique used to structure a study and to gather and analyse information into a systematic fashion.

3.3.1 EXPLORATION OF THE TOPIC

This was concerned firstly with the identification of participants to participate in the study, secondly, the conducting of interviews and, thirdly, data analysis and observation of the necessary ethical procedures.

3.3.2 POPULATION OF THE STUDY

According to Polit and Beck (2012:738) population is the entire set of individuals or objects having the same common features. Nieswidomy (2012:146) describes population as a complete set of persons or objects that possesses some common characteristics of interest to the researcher. However, Haber and LoBiondo-Wood (2014:581) define target population as a set of cases about which the researcher would like to make generalizations and accessible population as the one that meets the target population criteria and that is available. The target population of this study was the non-psychiatric trained nurses who worked in the Casualty/Emergency Department of the selected hospital for at least a minimum of one year. The accessible population was obtained from one general hospital in the O.R. Tambo district.

3.3.3 SAMPLING

Sampling is the process of selecting a portion of the population to represent the entire population (Polit & Beck 2008:765). Holloway and Wheeler (2010:589) concur and add that sampling is a purposeful selection of an element of the whole population to gain knowledge and information. According to Nieswiadomy (2012:154) subjects are chosen by the researcher whom he believes represent the accessible population. In this study, the researcher preferred a non-probability sampling approach and used purposive sampling which seeks participants that experience the process or change under study (Macnee & McCabe 2008:208). This kind of sampling is sometimes referred to as judgmental sampling because it selects individuals that meet the criteria for inclusion.

The participants were consciously selected for inclusion in the study in a manner that would represent the population groups of interest (Haber & LoBiondo-Wood 2014:235). Given that the research design was qualitative, phenomenological, exploratory and descriptive, the sample size was appropriate and adequate, composing of 5 general professional nurses (bridging) and 3 enrolled nurses (staff nurses). Appropriateness refers to the degree to which participants and the selection method fit the purpose of the study whereas adequacy refers to the sufficiency and

quality of data obtained from the participants. In other words, the relevance and completeness of the data resulted in saturation, a point where no new more information was obtained. The number of interviews depended on the data saturation i.e. the point at which all new information was redundant in relation to information already collected (Polit & Beck 2012:62).

The researcher had reasonable control over the composition of the sample by means of primary selection and assessment of the suitability of participants before interviews were conducted. In other words, the researcher was able to control the selection of interviewees into a sample by means of purposive sampling. It was the assumption of the researcher that the prospective participants had the required knowledge for the study. All participants had to have at least one year's working experience in the casualty/emergency department.

The criteria for selection into the sample included that the nurses participate voluntarily; that they have at least a year's experience in the field; that they had been allocated to casualty/Emergency Department and were either General Professional Nurse (Bridging) or Enrolled Nurse (Staff Nurse).

3.3.4 DATA COLLECTION

Polit and Beck (2008:367) describe data collection as the phenomenon in which researcher's interest ultimately captures and translates information into data that can be analyzed using high-quality data methods. In this study, after appropriate sampling, data were collected by means of individual/personal interviews.

Each participant was interviewed once, using a semi-structured interview method and a voice recorder. The researcher used the formal, individualized, semi structured interviews during data collection. Formal means that the interviews were pre-arranged and the general interviewing procedure was explained before obtaining informed consent. Rapport was established by making an attempt to put the participant at ease through introductions and informing them about the study a day before the actuals interview.

The researcher always tried not to be influenced in any way by preconceived ideas, beliefs, or theories by 'bracketing' any value judgments that might have had a subjective impact on data collection or any stage of the investigation. Sometimes a conscious effort was made to keep these beliefs to a minimum degree when the process of "bracketing" could not be completely adhered to.

On the day of the actual interview, the researcher tried to put participants at ease before asking the central question by conducting light conversations about general issues at first and then worked towards the central question. Interviews were conducted in English as their choice of language, during times and at places that were most suitable to the participants. Some interviewees preferred the matron's office and others preferred different private rooms in the department.

Interviews were conducted with both general nurses (bridging) and enrolled nurses (staff nurses). A voice recorder was used and field notes were taken during the interview sessions, which took about 30-45 minutes. Macnee and McCabe (2008:176) state that during the interview a researcher should take field notes that may include noting the participant's tone, expressions and associated actions and what is occurring in the setting.

The participants were asked one question phrased thus: "Could you describe your experiences of caring for mental health care users during the 72 hour observation?" The rationale for phrasing in this way was for simplicity and uniformity. The question was open, to allow participants to speak freely.

Some of the strategies used to facilitate communication were for example paraphrasing, clarification, reflection, questioning and probing. Follow up interviews were conducted with some of the participants at least one week after the interview where necessary, to validate the information recorded and where the meaning of statement(s) was not clear. This was also done to evaluate whether participants' experiences were reflected during interpretation. The data collection process for this study took approximately 3 months.

 Data collection was carried out at private rooms and at times that were convinient for the participants. All of the participants were interviewed at their work place

during their break times. Permisssion to interview the participants was sought and secured directly from them. Eight (8) non-pyschiatric trained nurses were interviewed, all of them from the casualty department of the hospital chosen for this study.The researcher used the langauage that the participants were comfortable with. Data from the voice recoder was transcribed verbatim soon after each interview had been conducted, whilst the information was still new and fresh in the researcher's mind. After transcribing, the data was analysed using the eight Tesch steps for analysis in order to shape the participants' responses. Thereafter, the raw data was also sent to an independent coder for analysis. This is an advanced practitoner in nursing who has experience in qulitative research and was asked to do coding using the same eight steps by Tesch (1990).

FIELD NOTES

Field notes will be described according to different stages of data collection.

- Setting up appointments

The researcher went to the relevant unit to make arrangements for interviews. The participants were keen to participate in the study and the researcher made appointments following their off times.

- Interviews

In general, all the participants were open and keen to air their views on how they cared for mental health care users. As a nurse who was familiar with this unit, the researcher learnt new things from the participants. Every participant signed the consent form before starting an interview. In the course of the interviews, the researcher could not help but notice that two of the participants were very unhappy about managing mental patients. The two spoke in a low voice, appeared very nervous (for example playing with a pen) and avoided eye contact.

TRANSCRPITION FROM VOICE RECORDER

The researcher did not experience problems with the voice recorder. Every interview was transcribed immediately after the interview. The researcher liaised with the supervisor and independent coder.

3.3.5 DATA ANALYSIS

According to Holloway and Wheeler (2010:179) data is analyzed through coding and categorizing. Coding is the process by which concepts or themes are identified and named during the analysis. Data are transformed and reduced to build categories which are named and given a label. Through re-emergence of these categories, theory can be evolved and integrated (Macbee & MacCbe 2008:184). For this study, non-psychiatric trained nurses' experiences regarding 72 hour assessment were coded depending on their responses after the voice recorded interviews were transcribed verbatim and analysed using the Tesch eight steps (Creswell 2014:158). The raw data was also sent to an independent coder (advanced practitioner in nursing who has experience in research) for analysis and was asked to do coding using the eight Tesch steps. After working independently with the data, there was a meeting between researcher and the coder. A consensus was reached independently on the themes and sub-themes.

During the inquiry process, the researcher applied "*intuition*" in an attempt to develop an awareness of the lived experiences of the participants. The process requires the researcher to become totally immersed in the phenomenon under investigation, aided by the participants' descriptions. This is a qualitative method used to discover and develop understanding of experiences as perceived by those who are living the experience (Macnee & MacCbe 2008:205).

Analysis of data in qualitative studies therefore involves an examination of text rather the numbers (Bink, van De Walt & van Rensberg 2012:193). Frequently, a massive amount of data in the form of text will be gathered, which makes analysis extremely time-consuming. Researchers using qualitative approaches tend to spend hours reflecting on the possible meanings and relationships of the data. This type of analysis is described as 'hands-on-process' during which the researcher becomes

deeply immersed in the data. It is sometimes referred to as 'dwelling' with the data. Generally, data analysis is not a distinct step in the qualitative research studies process as it can be done concurrently with data collection. Breaking down qualitative data in segments helps the researcher to better understand it. With regard to this study, after data had been analysed, the themes were refracted through the Theory of Health Promotion in Nursing by Botes (2006).

3.4 ETHICAL CONSIDERATIONS

Permission to conduct the study was obtained from Walter Sisulu University Ethics Committee, Provincial Department of Health (Research Coordinator) and from the Chief Executive Officer of the hospital where the study took place. Informed consent was obtained from each participant in the study (Refer to annexures as attached).

The researcher observed and adhered to the basic principles of research ethics particularly following the advice of Holloway and Wheeler (2010:54) that ethics for health researchers are concerned with guiding professionals to protect and safe guard the interests of clients. These authors also emphasize a framework of other moral norms that encompasses principles, rules, rights, virtues and outline four basic principles as pivotal to this framework:

- The **respect for autonomy**

  Respecting the decision-making capacities of autonomous persons means that the participants are allowed to make a free, independent and informed choice without coercion. The concept of respect for autonomy includes advice to the researcher to consider the social nature of individuals, the impact of their choices and actions on others and the emotions involved in the process of research. The primary consideration in any research study is to protect the dignity, rights, safety and well-being of participants. The participants were requested to participate voluntarily in the study because of their right to self-determination and the researcher guaranteed individual privacy. The purpose of the study, the role of participants and the use of voice recorder during interviews were explained and that if participants so wished, they could have access to the transcriptions of the interviews. The participants were also

informed about the independent coder, who would have access to their information but not their names.

- The **principles of beneficence** and **no maleficence** (do good, do not harm) This principle demands that benefits outweigh the risks for the individual and the wider society. The principles set up by the World Medical Association (WMA) add that risks must be carefully assessed and weighed against benefits not only for the population as a whole but also for the individual and these risks should be kept to a minimum. Houser (2012:55) states that human subjects can be harmed in a variety of ways, including physical harm (e.g. injury), psychological harm (e.g. worry, stress and fear), social harm (e.g. loss of friends or one's place in society) and economic harm (e.g. loss of employment) and in this study the researcher strived to minimize harm and achieve best possible balance between the benefits to be gained from participation and risks of being a participant.

- The **principle of justice** implies that the research strategies and procedures are fair and just. In a multicultural society this includes proper representation in research samples and respect for diversity (age, gender, disability and sexual orientation) including ethical considerations which are:

  - ➤ **Veracity (truth-telling)** in health care involves an accurate flow of information that is comprehensive and takes account of the participant's understanding. These features are important for gaining informed consent for participating in research. The rule of 'truth-telling' links to the principle of autonomy. Only people involved in research should have access to data and this was explained to all participants during interviews

  - ➤ **Privacy** is also part of the principle of autonomy. The researcher respected privacy of the participants, a factor linked to confidentiality. To ensure anonymity, individuals were kept nameless by using identification codes.

  - ➤ **Confidentiality** in healthcare generally is recognized as underpinning the patient-practitioner-researcher relationship. Without such confidentiality, there would be no basis for trust in these encounters.

Information can only be given a third party with the consent of the research participant. All those involved in research need to be aware of their ethical and legal duties and ensure systems are in place to protect confidentiality. In the publication of results, the names of the participants will not be revealed.

➢ Ethical rule of **fidelity** concerns the notion of faithfulness or loyalty. Traditionally, professional loyalty concerns giving priority to the participant's interests. With respect to this study, the researcher justified research not only to the research ethics committee but also to participants, superiors and gatekeepers. He recognized the right of participants to refuse participation in the project or to withdraw from it if they wished and it was emphasized that the participants would not be victimized upon withdrawal.

Description and formulation of guidelines for the non-psychiatric trained nurses

Data collected from research was used as a basis for formulating guidelines to be used by casualty non-psychiatric trained nurses when caring for the mental health care users on 72 hour observation to promote, maintain and restore mental health as an integral part of health. Literature was used as an aid in the formulation of these guidelines.

3.5 TRUSTWORTHINESS

Macnee and McCabe (2008: 170) state that trustworthiness involves measures taken to ensure that errors are prevented during the data collection and analysis. In qualitative research a Rigor is the term used for the strict process of data collection and analysis and as overall quality of this process. The four criteria of trustworthiness were used as follows:

3.5.1 Truth value using the strategy of credibility

Brink et al. (2012:172) state that credibility alludes to confidence in the truth of the data and the interpretation thereof. The investigation must be done in such a way

that the findings demonstrate credibility, in other words, that the reader will believe them. Confidence in the truth value can be established through the following techniques:

- **Prolonged engagement**

  Sustained involvement helps to build trusting relationships and rapport that are necessary to elicit accurate and thorough responses.

- **Persistent observation**

  This is done by consistently pursing interpretations in various ways. The researcher looks for multiple influences through a process of continual and tentative analysis, and determines what counts and what does not.

- **Triangulation**

  This is the process of using one or more than one approach or source to include different views in order to look at a phenomenon from different angles (Macnee & MaCcbe 2008:172). In this study, the semi-structured interviews and follow up interviews were done and field notes were taken. A combination of descriptive, qualitative, explorative and contextual designs were applied. The researcher worked with an independent coder and also enlisted the help of his supervisor. Eight Tesch steps were used and literature control was conducted.

- **Reflexivity**

  A qualitative researcher has to be sensitive to the ways in which the researcher and the research process have shaped the data (Houser 2012:427). This was taken into consideration in this study.

- **Member checks**

  This refers to assessing the intentionality of the participants to correct obvious errors and to provide additional information. The emerging findings of the study are taken back to the participants in order for the interpretations of the data, as well as the adequacy thereof, to be discussed and confirmed. This step was carried out in this step.

- **Peer Examination**

  With regards to this point, an expert in qualitative research was identified to look at the standards of this research. Thus, the services of a colleague were acquired as an independent coder.

3.5.2 Transferability

According to Macnee and MacCabe (2008:172) transferability refers to the extent to which the findings of a study are confirmed by or are applicable to a different group or in a different setting from the one where data was collected. According to Brink et al. (2012:173) transferability is enhanced by:

- **Thick descriptions** entailing the collection and provision of sufficient detailed descriptions of data within the given context and reportage on them. **Purposive sampling** maximizes the range of specific information obtained from and about the particular context, by purposefully selecting the participants in terms of knowledge of the phenomenon under investigation and the locations. All these elements were taken into account in this study as already outlined above.

- **Data saturation**

  This situation occurs when additional participants provide no new information and when themes that emerge become repetitive. The sample is then considered adequate and the data are considered rich and thick. This was obtained in this study and this aspect was pointed out earlier in this chapter.

3.5.3 Consistency using the strategies of dependability

According to Brink et al (2012: 172) dependability refers to the provision of evidence such that if it were to be repeated with the same or similar participants in the same or similar context, research findings would be similar. Further techniques to ensure dependability are stepwise replications in which all steps are replicated by two or more teams, who deal with data independently and then compare the findings.

3.5.4 Neutrality using the strategy of confirmability

Macnee and MaCcabe (2008:170) state that confirmabilty is the consistency and repeatability of the decision making about the process of data collection and data analysis. This is noted in the strategy of audit trail. The latter is ongoing documentation regarding the researcher's decisions about data analysis and collection process. Documentation from the audit trail may include field notes about the process of data collection, methods notes regarding approaches to categorizing or organizing the data. In this study, the researcher consistently referred to methods and field notes.

Table 1: Application of Trustworthiness

STRATEGY	CRITERIA	APPLICABILTY
Credibility	Prolonged engagement	The researcher tried to maintain truthfulness of the findings by focusing on the lived experiences of participants. During data analysis, the researcher also reviewed voice recordings and continuously referred to the transcripts during the stage of writing the research report. Follow-up interviews were conducted.
	Persistent observation	
	Triangulation	The researcher looked for multi-influences through a process of continual and tentative analysis and determined what counted and what did not. The eight Tesch steps were used.
	Structural coherence	Semi-structured interviews follow-up interviews and

		field notes were done. A combination of descriptive, qualitative, explorative and contextual design was applied. The researcher worked with an independent coder and supervisor. The eight Tesch steps were used during data analysis, a literature control was done.
	Reflexivity	
	Member checks	
	Peer examination	
		The focus was on the nurses' experiences. Results were refracted through the Theory of Health Promotion in Nursing. Field notes were taken in this study
		The emerging findings were taken to the participants in order for the interpretations to confirm adequacy and credibility. Follow up interviews with participants and field notes were taken. The service of a colleague as an independent coder, was acquired
Transferability	Thick descriptions	A complete description of the results and literature control to maintain transferability was done.
	Purposive sampling	The sampling method used was purposive with no prior selection.
	Data saturation	When the sample was considered adequate and the data to be rich and thick, the eight Tesch steps were used to analyse data.

Dependability	Code-recode procedure	Raw data was also given to an independent coder, only after the researcher had done his own coding (Refer to annexure G). There was a meeting between the coder and the researcher to discuss themes and sub themes.
	Dense description	Research methodology fully described
Confirmability	Audit-trail	Data analysis protocol transcription was used in this study.

3.6 Conclusion

The description of the research design and methods was meant to provide the reader with a global picture of the research methodology. The researcher negotiated entry into the research field by requesting permission to conduct the study from the Provincial Department of Health (Research co- coordinator) and from the Chief Executive Officer of the hospital where 72 hour observation was practiced. Informed consent was obtained from each non-psychiatric trained nurse participating in the research. Data was collected by means of interviews. The researcher was committed to ensuring trustworthiness and credibility of the study. Data was analyzed and themes were discussed following interview texts. From the themes, recommendations were made.

CHAPTER 4

RESULTS /FINDINGS

4.1 INTRODUCTION

The previous chapter dealt with the description of the research methodology used in this study. Analysis of data and the findings of the inquires are discussed in this chapter. The research findings of the experiences of non-pyschiatric trained nurses caring for the mental health care users on 72 hour observations will be discussed in this chapter using the identified themes and sub-themes.

4.2 RESULTS

Table 4.1 shows an overview of the major themes and sub-themes from the experiences of non-psychiatric trained nurses caring for mental health care users on 72 hour observations at the hopital chosen for this research in the O.R. Tambo district. The researcher obsevered that in terms of the findings, the perceptions between the professional nurses (bridging) and enrolled nurses (staff nurse) were similar in spite of the fact that they have different scope of practice. In any case, the two types of nurse work hand in hand with each other. A central question that was asked during the interview was: "Could you describe your experiencess for caring for mental health care users during the 72 hour observations. "

Table 4.1: Themes and Subthemes

THEMES	SUB-THEMES
1. Feelings experienced by non-psychiatric trained nurses.	1.1 Lack of safety.
2. Attitudes of these nurses towards Mental Health Care Users (MHCUs)	2.1 nurses have positive attitude 2.2 Experience in Nursing
3.Lack of knowledge.	3.1 Fear.

4.Challenges facing these nurses.	4.1 Infrastructure not conducive for 72 hour observation.
	4.2 Inability to administer medication at prescribed times.
	4.3 Aggressive behaviours of relatives.
	4.4 Shortage of drugs.
	4.5 Danger allowance.
5. Strategies used by nurses to cope with a violent mental health care user.	5.1 Physical restraints.
	5.2 Chemical restraints.
6. Need for support from security staff 7. Lack of policies or protocols for mental health care users	

4.3 THEME 1: FEELINGS EXPERIENCED BY NON-PYSCHIATRIC TRAINED NURSES

In the clinical setting, nurses care for different types of patients and with experience they develop skills on how to manage each type but in this study, the non-psychiatric trained nurses, in spite of having had at least a year's experience, expressed insecurity or fear when caring for mental health care users.

4.3.1 LACK OF SAFETY

This was revealed by four (4) of the participants. Caring for patients with mental health problems was felt to compromise work safety because participants feared that they could not predict behaviour or control mental health care users for which they were responsible. Some of the participants said, *"I am not satisfied concerning risks that we are taking and our safety is compromised"* whilst another participant

commented, "*I am not happy concerning my safety... some of these people are violent".*

Every patient that comes to the hospital under study, has to be first seen in the Casualty/Emergency department as standard entry procedure for any patient. Nurses at the research site were expected to attend to every patient that came their way. One participant indicated fear of mental health care users because they each exhibited different behaviours, "*I feel exposed because some are very aggressive… and some come with weapons.*" The absence of security personnel or measures to manage such patients influenced the way that nurses viewed the patients.

4.4 THEME 2: ATTITUDES OF NURSES TOWARDS MENTAL HEALTH CARE USERS

Diverse attitudes were noted among non-psychiatric trained nurses with regard to their experience in the ward.

4.4.1 POSITIVE ATTITUDE

Two participants revealed very positive attitudes for caring for mental health care users, regardless of current influences. They attributed this to their life experience and the recognition of mental health being an integral part of holistic nursing care. They related this to positive experiences in caring for patients with mental health problems resulting from education and interaction with the local mental health team and supportive nurses in the ward. Older professional nurses (bridging) with more than 5 years working experience in the ward showed confidence in caring for mental health care users because they had developed skills to do so. As one participant said, "*I have developed positivism… I am positive about looking after these clients".* Such positive minded nurses explained how they had developed nurse-patient relationships, receiving positive feedback and information that assisted them to care more effectively for mental health care users. It was noted that the different attitudes and coping strategies were to a large extent dependent on working experience in the ward. The longer the experience, the more positive the attitude turned out to be.

4.4.2 EXPERIENCE IN NURSING

Older nurses expressed worry that they do not have the basics of how to care for mental cases because the issue had not been in their training. Nonetheless, with experience they had developed caring skills which they were applying during their practice when faced with a mental case. One participant said, "*It is very painful because I have no idea of how to manage them but I do [care] with experience*". Professional nurses (bridging) with less than 5 years working experience and enrolled nurses (staff nurses) with more than one year's working experience in the ward had negative attitudes towards the mental health care users as seen for example, through this comment: "*I do have a problem working with these people*". Reference to mental health care users as "these people" reveals impatience, irritation or downright derogation.

The professional nurses also proclaimed that they were different from other nurses. Some of the comments that capture this situation are: "*I am feeling bad because I have no special course, so people with psychiatric nursing should care for them*" and, "*I am not happy unless there can be a unit created* [and attended to by] *psychiatric trained staff*". The objection that the professional nurse was making here is that she was expected to perform all the skills necessary for a professional nurse without training in psychiatry.

4.5 THEME 3. LACK OF KNOWLEDGE

Being knowledgeable helps nurses to work with confidence. It emerged that the nurses in this study were expected to care for mental health care users in the casualty department, yet they had not received relevant training.

4.5.1 Fear

When one lacks knowledge, s/he experiences fear because s/he is not confident enough and not sure whether s/he is doing the right or wrong thing. Nurses who are junior to general professional nurses and enrolled nurses sometimes ask the latter two for their opinions but general professional and enrolled nurses revealed that they had no good answers to some of the questions their juniors asked about mental

health care users. This stemmed from the fear and lack of knowledge that even those expected to take leadership roles had concerning the management of mental health care users. As one such participant said, "*We are afraid, we are not hating them…."* Some participants indicated that they were willing to care for the mental health care users to the best of their ability and suggested that to do so, the department needed to offer short courses on how to take care of these users. One area that was pinpointed as lacking was the ability to interview mental care users and also how to communicate with them in general. These are some of the comments that were passed: "*We need orientation because we are neophytes when it comes to mental cases", "there should be workshops, we have no comprehensive course and we need introduction on how to manage psychiatric patients", "I don't know what do when I come to mental case ", and "I am scared when I am nursing these patients…"*

Rurality was reported to lead to long delays in assistance, leaving nurses to contend with situations that were frightening or were not sure how to manage. This contributed to a sense of vulnerability and unsafe workplace as one participant said, "*There is always a delay for them especially if she is not violent".* This lack of control versus the nurses' sense of responsibility translated to anxiety. Some suggesting workshops or some kind of orientation about dealing with mental health care users in order to allay anxiety and provide optimal care to mental health care users. Fear and anxiety was reported to be at its highest at night when there were less staff in the ward and indeed, the whole hospital. The need for further education to gain skills and knowledge concerning mental cases was reiterated by virtually all the participants.

4.6 *THEME 4:* CHALLENGES FACING THESE NURSES

Participants reported experiencing different challenges caring for mental health care users and other cases in the Emergency/Casualty ward. All challenges were said to compromise effective nursing practice.

4.6.1 INFRASTRUCTURE NOT CONDUCIVE FOR 72 HOUR OBSERVATIONS.

It was widely acknowledged by all participants that every patient deserves to be treated in an environment that is conducive for optimal health care to be rendered, and that such an environment, with regard to this study, should not be detrimental to the lives of mental health care users. Mental healthcare users, it was agreed, should be in an environment where they do not acquire nosocomial infections. The participants reported that the buildings and fittings were designed to suit medical care not mental health needs.

All the participants in this study reported that the mental health care users were not treated fairly, participant said, "*They sit on chairs because there is no space for them …the challenge of space is a big problem.*" Another participant said, "… *so they sit on the passage during the 72 hour observation.*'" This proves the point that mental health care users were not treated well as nobody can or should be treated from a chair for three days. Since the Emergency/Casualty ward is first entry level to the hospital, mental health care users during the 72 hour observation were said to be mixed with medical patients, a risky situation for the mentally disturbed. Regarding this point, one nurse said, "*The patient can come [being] mentally disturbed and end up catching a medical condition…this environment is having other patients, they are not safe.*"

All of the participants viewed this environment of care as unconducive and the staff indicated that as a result they were not happy working in such an environment. To illustrate this point, one of the participants said*, "We are frustrated as nurses working in an environment like this especially when there are patients who are assaultive."* They further revealed that some of health care workers were bitten by these patients and even other medical patients were also at risk of being bitten especially immobile patients. Other related comments were: "*It is very congested, not therapeutic…"*, "*If they are violent they can harm other patients especially those who are bedridden,"* "*A medical officer was fisted…"*, and "*…they hit the relative of a medical patient…."*

Participants also pointed out that was not fair to hospital staff to have psychiatric cases in an environment where the movement of such patients was difficult to control. Instances were cited in which at times a nurse wanting to give treatment to a patient would discover that the patient was missing – outside with a relative or having gone missing with no explanation. One participant said, "*…they are missing, the place is not burgled* [well-secured] and another, "*They move up and down with their relatives…."*

4.6.2 INABILITY TO GIVE MEDICATION AT PRESCRIBED TIMES.

Participants indicated that during the 72 hour observation, the mental health care users should be given treatment either 6 hourly or 8 hourly as prescribed by the doctor depending on the condition. Participants indicated that administering treatment at prescribed times was a big challenge. As one participant indicated, "*…but we cannot give as prescribed we only give when the patient is violent,*" indicating that mental health care users were mixed with medical patients leading to pressure of work. The participants also indicated that they focused more on the medical patients, "*….we [nurses] focus more on medical patients…*" because medical patients are the ones that were trained to handle and felt competent to handle, as opposed to psychiatric patients. Other statements that indicated pressure of work due to overcrowding include: "*…there are a lot of patients in casualty and it's impossible to give treatment as prescribed…"*, and "*…we do not stick to times [of medication] because our unit is overcrowded…."*

4.6.3 SHORTAGE OF DRUGS

During the 72 hour assessment mental health care users are given for example haloperidol 8 hourly as part of management regimen. In this study, five (5) of the participants reported a shortage of drugs. As one participant said, "*Sometimes we run out of drugs in this hospital…so they become violent and we don't have drugs…."* Participants indicated that in response to this situation they would go and ask for drugs from a psychiatric unit nearby, especially when there were aggressive mental health care users. This improvisation however, did not go well all the time. Participants indicated they sometimes encountered problems with nurses from the

psychiatric unit. In the words of one participant, *The nurses working at the psychiatric institution do not understand us when we go and ask for help in terms of drugs and yet they have the skills...."*

4.6.4 DIFFERENT BEHAVIOURS OF PATIENT'S RELATIVES

Participants also experienced challenges with some families of mental health care users. Nurses indicated that it helped if family members assisted in calming their relative under 72 hour observation. Instead, some family members were said to refuse to cooperate   and shifted all the responsibility to nurses. As one participant said of such relatives who immediately leave the ward, "*They are complaining, saying it is not their duty."*

Participants also indicated that they tended to fail to answer fully some of the questions being asked by the relatives, and as a result, some relatives would quarrel with nurses. Much as the nurses in the Emergency/Casualty ward always referred relatives and their queries to psychiatric trained nurses, but they felt that they should at least be able to give some answers instead of referring all questions to psychiatric trained nurses*.*

Participants also encountered problems with relatives who once having brought a mental health care user to hospital turned their backs on the patient. A quote to that effect is: "*It is very difficult because they [relatives] believe that when the patient is at hospital they want to be hands-of...."* The following also prove the same point: "*They feel very angry to us because they do not feel comfortable staying with them...", "...they become irritable...",* and "*...some relatives tend to leave this patient alone un-attended even if you have explained to them the procedure."*

Another problem that was cited by participants was the interruption of the 72 hour observation by relatives. Some relatives were reported to have found it "strange" to "stay" in the hospital with a patient during this period and tended to have excuses for leaving, such as that their homes were far away and they needed to leave as soon as possible and in some instances, taking with them the mental health care user before the end of the 72 hour observation. Incomplete observations meant that the patient did not benefit from the 72 hour observation.

4.6.5 DANGER ALLOWANCE

The participants argued that because they experienced different and challenging types of mental health care users, they were entitled to a danger allowance given that some of the patients were very violent, posing a lot of risk to the nurses. Comments included: "…*we are not getting any allowance* for *managing these patients*" and "…*there must be danger allowance.*" The participants also felt that even if the mental health care user might not stay long in Casualty department, but that moment puts staff at risk nonetheless. As one of the nurses observed, *" … we are at risk and some of the staff members get assaulted by these clients".*

4.7 STRATEGIES USED BY NURSES FOR COPING WITH A VIOLENT PATIENT

- **Physical restraints**

Nurses indicated that it was impossible to follow the instruction that they should not restrain patients because some of the users were very aggressive, even after sedation considering that the medication does not work instantly. One nurse asked, "…*How can you even give medication to a violent patient?*" Some of the nurses justified the use of restraints thus: "*As long these patients are kept with other medical patients they must be restrained to protect other patients".*

- **Chemical restraints**

During the 72 hour observation of these users, participants indicated that there was no rehabilitation done or any counselling done where necessary. They were only given injections to sedate them when they were violent. Participants indicated that as non-psychiatric trained nurses, they lacked appropriate communication skills to deal with mental health care users. All of the participants agreed that they just sedated the mental health care user and left him/her wherever he/she was, for example, in a corridor awaiting blood results under the watch of relatives.

4.8 SUPPORT FROM SECURITY STAFF

Participants reported that when violent mental health care users report to the casualty/emergency department, they enlist help from hospital security guards to subdue the patient in order to inject the latter. In the words of one of the participants, *"I just call a security [guard] to hold them when I am to inject the patient"*. As indicated above, the environment is not secure for keeping mental health care users who are not accompanied by relatives and as such, nurses ended up asking the security team to look out for patients who might abscond.

4.9 LACK OF PROTOCOLS OR POLICIES

Participants also reported that there were no policies for unaccompanied patients and as such sometimes they experienced problems when a patient absconded. Under these circumstances, nurses were required to write statements and yet there was no protocol known to them.

•shortages of drugs •danger allowance •security support •lack of policies	•strategies used to cope with a violent user •enviromental factors	•feelings experienced by these nurses. •Attitudes of these nurses •lack of knowledge •family emotions
SOCIAL DIMENSION	**PHYSICAL DIMENSION**	**PSYCHOLOGICAL DIMENSION**

social dimension

phyisical dimension

psychological dimension

non-psychiatric trained nurse
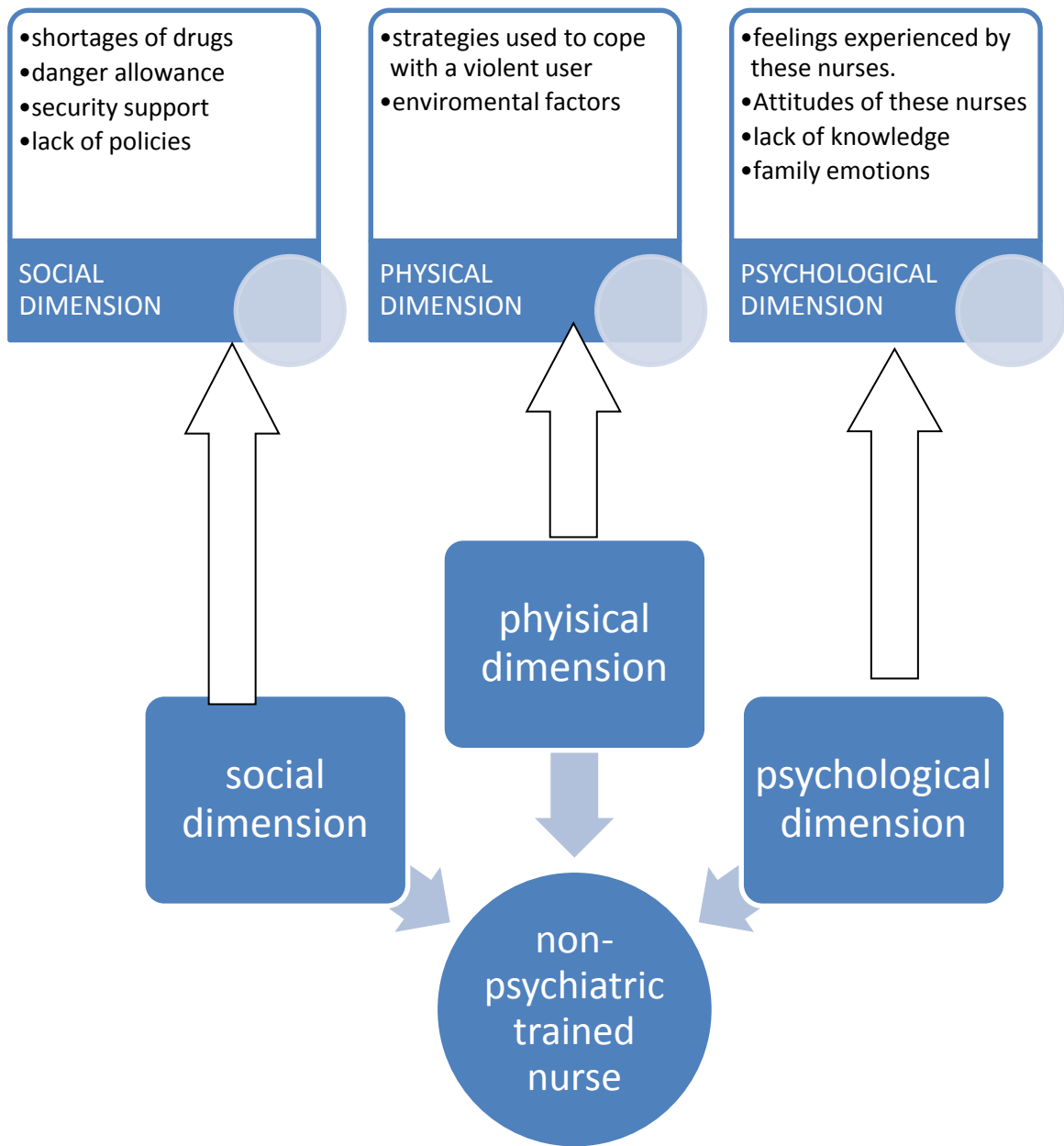
Table 4.2.

CHAPTER 5

DISCUSSION, GUIDELINES, RECOMMENDATIONS, LIMITATIONS AND CONCLUSIONS

5.1 INTRODUCTION

In the previous chapter the results of this study were discussed and compared with relevant literature. In this chapter, guidelines are formulated as supportive action for the non-psychiatric trained nurses. Following this, the limitations encountered during the conduct of the study are described. Thereafter, conclusions and recommendations are presented.

5.2 DISCUSSION OF THE RESULTS

The above themes and sub-themes reflect the patterns of interaction between the non-psychiatric trained nurses' internal and external environment within the ambit of Theory for Health Promotion in Nursing by Botes (2006) which stipulates that nursing environment is an interactive process with patients' environment with the overall aim being promotion of health. The results of this study are further discussed in light of previous research and literature for the purpose of substantiating the results.

In this research study, it became clear that the caring for mental health care users on 72 hour observations interfered with non-psychiatric trained nurses in three major areas: (1) Psychologically – which includes the intellectual capacity and their emotions, (2) physically and (3), socially.

5.2.1. PSYCHOLOGICAL DIMENSION

According to the theory for Health Promotion in Nursing by Botes (2006:5) this dimension includes the intellectual capacity, emotional and volitional process of the individual/family/group/community. Intellect refers to the capacity and the quality of the psychological processes, thinking, association, analysis, judgment and understanding which an individual is capable of. Volition is the process of decision making in the executing of a choice by the individual or group.

Psychologically, the participants appeared to be in need of knowledge and skills necessary for the management of a mental health care user particularly because they dealt with such patients almost on a daily basis. Nurses indicated unhappiness about caring for mental health care users because they did not know how to communicate with the latter and also experienced some difficulties when dealing with families of mental health care users.

5.2.1.1 FEELINGS EXPERIENCED BY THE NON-PYSCHIATRIC TRAINED NURSES

Generally, feelings are the physical sensations we experience in our bodies. So feeling is a communication from the body to the mind. Thus, according to this view, participant's feelings differ from one person to another. Feelings are determined by how we see, think and do things as individuals.

- **Lack of safety**

In the clinical setting nurses care for different types of patients and with experience they develop skills on how to manage each situation but in this study the participants reported fear when caring for mental health care users regardless of working experience in the casualty/emergency department. The participants were frustrated and anxious about caring for mental health care users because some mental cases had proved to be violent, with some said to even be armed.

Lack of knowledge on how to care for mental health care users presenting to casualty/emergency department made the nurses feel traumatized. Zolnierek and Clingerman (2012:229) point out that when one is caring for mental health care users s/he must become more cautious but the situation in this study brings the question: how would nurses starting to exercising caution if in the first place they did not know what to do when caring for a mental health care user? It is the opinion of the researcher that the participants felt unsafe when caring for mental health care users and yet it's every employee's wish to feel safe at work and be satisfied. Safety issues are an important topic in today's workplace, especially with the rise of incidents that compromise safety in the work place. Lack of safety proved psychologically traumatizing and induced anxiety, worsened by lack of professional

knowledge on how to care for mental health care users. Each participant had developed, using their own discretion, different strategies and attitudes towards caring for mental health care users.

A.ATTITUDES OF NURSES TOWARDS MENTAL HEALTH CARE USERS

Attitude refers to one's predisposition or tendency to respond either positively or negatively towards a certain idea, person or situation.

Some nurses have positive attitudes

In this research, some of the participants expressed a clear dislike of caring for mental health care users, although some indicated that their beliefs were more positive than their prevailing attitude. A number of factors appeared to have influenced these attitudes, such as the high perception of danger due to unsafe environment, and the lack of time, support and education. Attitudes amongst non-psychiatric trained nurses were to an appreciable degree, determined by the length of experience in the ward. The "older" professional nurses (bridging) with more than 5 years in the ward tended to respond positively when caring for the mental health care users.   This was because the nurses had developed skills on how to manage mental cases. Much as that was the case, the nurses indicated that they did not have a professional basis of what they were doing and would like to be oriented on the matter.

The professional nurses (bridging) with less than 5 years working experience and enrolled nurses (staff nurse) with less than a year's experience in the ward had negative attitudes towards the mental health care users.

This showed that participants had different views in caring for mental health care users and these findings are supported by previous studies such as that of Reed and Fitzgerald (2005:251) who found that nurses in Australia had different attitudes towards mental health care users and this was echoed by Ndetei, Khasakhala, Mutiso, Mbwayo (2011:234). In this study, negative attitudes were dominant and this dominance might be due to the fact that nurses lacked knowledge of dealing with mental health care users, a finding that is supported by Aydin, Yigit, Inandi and

Kirpinar (2015:22) when they found that in Turkey attitudes of hospital staff towards mentally ill patients in a teaching hospital tended to be negative for the most part, for the same reason.

However, other studies have different findings from this study. Lethoba, Nentswera and Rankhumise (2006:8) found that in Gauteng, it was mostly more experienced general professional nurses who had a negative attitude towards mentally ill patients. This is in contrast with the findings of this study in which newly employed non-psychiatric trained nurses was the group that mostly had a negative attitude.

Working in the casualty/emergency is strenuous and the nurses in this study found it difficult to focus on mental health care users that they were not even sure how to deal with. As a result, they focused more on patients they were equipped to manage. In contrast, Sharlock and Happell (2006:13) found that nurses in Australia had positive attitudes towards people with mental health problems and acknowledged mental health care as their nursing work in spite heavy work pressure. This finding contrasts that of Suokas, Suominen and Lonnqvist (2009:161) which concluded that because of heavy work pressure led to nurses' negative attitudes towards mental health care users, to the point of suicide attempts among the worst affected nurses. In Chile, Valdivieso, Sirhan, Aquirre, Ivelic (2013:311) concluded that nursing students who had not yet trained in psychiatric nursing had positive attitudes towards psychiatric patients.

B. LACK OF KNOWLEDGE

Knowledge is a familiarity, awareness or understanding of someone or something, such as information, skills acquired through experience or education by perceiving, discovering or learning. Being knowledgeable also helps nurses to work with confidence and to perform their work with pride. In this study, the nurses placed in casualty department however, did not have any orientation regarding mental health care users. Ironically, they were expected to care for such cases.

- **Fear**

Some of the participants expressed concern based on the perception that mental health care users may be unpredictable and potentially dangerous. Most of the participants reported fear of these patients because they were not trained on how to manage them. As one participant said, "*We are afraid, we are not hating them.*" Some participants indicated that they were willing to care for the mental health care users but the department needed to run short courses for them on how to take care of these users. It was indicated that nurses needed more practical and emotional support in caring for patients with mental health problems due to stressful and complex nature of this work. They relied on their peers for support but many felt that this was inadequate due to poor attitudes or lack of expertise.

Fear is a chain in the brain that starts with a stressful stimulus and ends with the release of chemicals in the muscles, also known as a fight/flight response (http://science.howstuffworks.com/life/inside-the-mind/emotions/fear.htm/ptrintable retrieved 3/19/2015). Most of the participants cited anxiety stemming from lack of knowledge regarding the handling of mental health care users. These findings are supported by a study conducted by Mavundla et al. (1999:38) in general hospital setting in South Africa's Gauteng Province. Reed and Fitzgerald (2005:251) also arrived at a similar conclusion, that nurses do not feel comfortable caring for people with mental health problems despite ideas of advocacy and desire to help. This will explain why nurses are advised that should they have the opportunity to work in an emergency setting, they should look for a hospital that has formal orientation or internship program for at least 3-6 months at a minimum, preferably with some focus on handling mental health care users (http://.ena.org/membership/pages/whyemergencynursing.aspx cited 3/19/2015).

C. FAMILY EMOTIONS

Participants in this study also experienced challenges with some families of violent mental health care users who did not want to stay with their relatives for the procedure of 72 hour observation. Sentiments under this theme were presented verbatim earlier in this chapter. Such actions by relatives could be the result of being

fed up with the mental patient or might be as a result of unfamiliarity with the hospital setting. Some of the relatives did understand and stayed with their relatives in the casualty unit. Some relatives expected full responsibility to fall on the shoulders of the nurses.

Emotion, which is a person's state of mind and instinctive responses is linked to mood, temperament and personality so therefore the nurses feelings or experiences are always expressed through their behaviour when they are caring for mental health care users. Ngqoboka, Gmeiner and Poggenpoel (1999:45) also found that the anger and frustration experienced by families with a mentally ill patient is a common occurrence. The study confirmed that it is common for families of mentally ill patients to feel intensely angry, not only with the patient but also with each other and anyone they can think to blame. Thus families are affected in many ways by mental illness and because the affected party is someone they care for, it is likely that the illness has a serious emotional impact and relatives might be experiencing anger, confusion or a sense of loss and grief at how the person has been changed by illness (www.sane.org).

5.2.2 PHYSICAL DIMENSION

Theory for Health promotion in Nursing defines this dimension as any physical and chemical agents/structures in the external environment of the individual. The nurses in this study felt that their physical safety was at risk because of unsuitable ward environment compromising both the nurses and hospital's duty of care to provide a safe workplace. This environment had a number of variables that interfered with the improvement of nursing care, difficulty in observing the mental health care users and overcrowding which further interfered with communication with mental healthcare users because nurses did not have enough time to sit down and talk to mental health care users.

A. STRATEGIES USED FOR A VIOLENT MENTAL HEALTH CARE USER

Strategies of this nature (restraining mental health care users) entail physical restraint and physical contact (Mavundla, Poggenpoel & Gmeiner 1999:39).The

present research study correlates with the study mentioned above in that both physical restraints and sedation were used.

- **Physical restraints**

It is important to be respectful in the space of all mental health care users and be mindful of any physical contact. When giving care of any kind, prior negotiation of physical contact with the user is preferable. Involuntary confinement and a feeling of control can be distressing for anyone, particularly mental health care users and can preface an aggressive incident. Restraining patients in a hospital setting is totally unacceptable as this is a violation of their human rights. Nurses have indicated that they are instructed not to restrain patients although real practise in the ward indicates that they should, especially when a mental health care user becomes very aggressive. Some of the participants argued that some of the patients did not respond immediately to treatment and the same mental health care users were mixed with bedridden patients – a situation likely to result in disaster if the mental patient is not restrained. Restraint is generally used to prevent people with physical or mental disorders from harming themselves or others

In a study conducted by Moylan and Cullinan (2011:526) in New York, it was found that nurses waited for the violent situation to subside before deciding to restrain a patient. The study also found that there are situations where nurses could not avoid restraining the patient. The above study also indicated that nurses felt very limited in applying restraints due to restrictive procedures or fear of negative sanctions from administration. Consequently, Moylan (2009:41) argued that all staff working in acute psychiatric settings need intensive orientation to the general policies and and to some of the policies related to restraint use, as well as the training that includes actual practice of the techniques. However, it is suggested to avoid coercive practices and encourage respectful collaboration with the user and the people close to them.

- **Chemical restraints**

Chemical restraint is a term used to describe a pharmacological method used solely to restrict movement of a user. Sedative medication can be used for the

management of a disturbed behaviour. It is important that this practice is safely managed by adherence to evidence based guidelines. In this study, no counselling was offered during the 72 hour observation of these users. The users were given sedative injections. According to Mavundla et al. (1999:39) decisions involving the administration of medications and the manner in which the patient arrives at the medical facility, give rise to important considerations that can significantly affect the patient's response.

B. ENVIROMENTAL FACTORS

- **Infrastructure**

Every patient deserves to be treated in an environment that is conducive for optimal health care to be rendered and this should be an environment which is not detrimental to the lives of mental health care users. These users should not acquire nosocomial infections. The nurses in this study felt that their physical well-being and that of others was at risk because of the unsuitable ward environment. Nurses reported that the mental health care users were unfairly treated. For example, they were expected to sit on a chair for the whole 72 hour observation period.

All the participants in this study concluded that the environment of care was not a conducive environment. The nurses feel that the environment is poorly built to accommodate all types of patients served by the emergency department and staff was not happy working in an environment of that nature. This environment was so bad that some staff were reported to have been bitten by mental health care users and some bedridden patients had also been assaulted.

Sakr and Wardrope (2000:314) describe casualty department as a place for temporary treatment for simple diseases or injuries and a place which is well built, well ventilated and capable of seating more than 600 persons. However, Cooke, Higgins and Kidd (2003:46) argued that these wards need a rigorous review in terms of patient benefit (length of stay, bed availability, staff benefit (release pressure and stress on staff) and cost-effectiveness. Alakeson, Paride and Ludwig (2010:1637) argue that emergency rooms tend to be poorly equipped to deal with mental health needs resulting in increased pressure on staff.

- **Giving of medication**

The mechanism of action of drugs means that a drug can be effective for certain hours in the body and after sometime it needs to be given again and in mental cases, drugs are given to sedate the mental health care user during the 72 hour observation. Mental health care users are given treatment 6 hourly or 8 hourly as prescribed by the doctor. In this study, participants said they faced a big challenge of inability to administer medication at prescribed times because of violent mental health care users. Pressure of work also resulted in nurses focusing less on mental health care users. Some participants indicated that the emergency unit was overcrowded with more medical patients than the psychiatric ones, hence the uneven attention. In some instances, medication was not given to mental patients as prescribed because they would have gone missing.

According to Aronson (2009:599) medication is a process that is intended to be taken or administered to a person to prevent diseases; make a diagnosis; to test for possibility of an adverse effect; to modify a physiological, biochemical or anatomical function or abnormality. Failure to administer a drug at prescribed times can bring about a failure in the treatment process that can or has a potential to harm the patient because the process has fallen below some attainable standard. A similar study conducted by Alvisa, Arianna, Costaperaria and Vittorio (2009:185) came to this conclusion as well.

5.2.3 SOCIAL DIMENSION

Theory of Health Promotion refers to this dimension as the human resources in the external environment of the individual/family/group/community. Participants in this study demonstrated that the environment in which they care for mental health care users had different challenges that interfered with the improvement of patients.

A. DRUG SHORTAGE

The ministerial priority of availability of drugs is critical because it is the most used method to care for patients. In this study, most of the participants reported drug shortage. At times patients under 72 hour observations did not get adequate

medication. One participant indicated that they would go and ask for drugs from a psychiatric unit and at times not get a positive response from nurses in the psychiatric unit. The above findings tally with findings by Gonzalez (2013:1) who studied psychiatric care in Port Elizabeth, South Africa. In that study, healthcare workers reported that facilities in the area faced shortages of psychiatric drugs. The shortage of psychiatric drugs has been noted as a common problem in other countries as indicated by Yan (2012:47). The drugs in short supply include amphetamine mixed salts (immediate-release tablets and extended-release capsules), buprenoprine injection, diazepam injection, haloperidol lactate and decanoate injections, ketamine injection, lorazepam injection, naltrexone oral tables, trazodone tablets, and valproate sodium injection (Eban 2014:1).

B. SUPPORT FROM THE SECURITY STAFF

Hospital security is non-nursing staff but they were always needed during the caring of mental health care users. Security personnel was called in to hold down or subdue mental health patients so that injections could be administered. Unaccompanied mental health care users posed an increased threat since relatives were said to be very effective intermediaries. The role of security staff in helping administer treatment is also reported in the study by Mavundla et al (1999:39).

C. LACK OF POLICIES OR PROTOCOLS.

Nurses reported that there was lack of policies or protocols to be followed in dealing with both accompanied and unaccompanied mental health care users. Consequently, at times nurse experienced problems when a patient absconded and they were required to write statements in the absence of protocol. Similar findings were made by Mavundla et al (1999:39) who found that there was lack of policies or protocols for dealing with emergency situations in South African general hospitals. Lukens et al (2006:98) have a suggestion regarding this situation that psychiatrists must always be available at all times in the Casualty/Emergency Department.The nurses in this study felt entitled to a danger allowance given the risks they exposed themselves to.

D. DANGER ALLOWANCE

Owing to the very aggressive nature of some mental cases that present to casualty, nurses in this study were convinced that they should get a danger allowance. This is because they are predisposed to danger and this will motivate them to care for mental health care users because their life is in danger.

CONCLUSION

This chapter has shown the experiences of non-psychiatric trained nurses caring for mental health care users during the 72 hour assessment. It will be necessary for the department of health to assist them through various ways for them to be able to promote, maintain and restore   mental health of their patients as an integral part of health.

5.3 GUIDELINES AS SUPPORT FOR A NON-PYSCHAITRIC TRAINED NURSE

The results of this study show that the participants required assistance from the Department of Health. Nurses form the largest group of health care providers in South Africa. For this reason, they contribute significantly in the promotion, maintenance and restoration of mental health of the mental health care users as an integral part of health. Guidelines formulated here follow the Theory of Health Promotion in Nursing by Botes (2006:6) with its three dimensions – psychological, physical and social.

A. Psychological dimension

The psyche includes all intellectual, emotional and volitional processes of an individual/family/group/community.

Guidelines for psychological dimensions

- There must be orientation workshops on how to manage psychiatric conditions that present at a casualty/emergency department.
- There must be security all the time to ensure security measures such as screening patients with dangerous weapons.

- Newly employed non-psychiatric trained nurses need orientation of how to nurse mental health care users within six months of employment.
- They must be given pamphlets on how to manage mental health care users.
- There must be counseling done on the families of mental health care users.

B. Physical dimension

This refers to the physical and chemical agents/structures in the external environment of the individual /family/group/community. This is referring to anything that physical changes that the nurses can use for the improvement of their practice during the 72 hour observations.

Guidelines for physical dimension

- There must standardized protocol on what nurses should give to a violent behavior.
- Dedicated psychiatric assessment wards must be created.
- There must be a holistic approach to nursing practice.
- There is a need to have consistent access to psychiatrists at all times in the assessment ward.
- There must be orientated personnel at all times, specifically caring for mental health care users.

C. Social dimension

Theory for Health Promotion refers to this dimension as the human resources in the external environment of the individual/family/group/community. This is referring to all of the administrative duties that are supposed to be performed for easy, smooth running of the ward.

Guidelines for social dimension

- There must be availability of drugs all times as this will facilitate a smooth running of the ward with availability of drugs at all times.
- There must be danger allowance for the nurses caring for mental health care users. Human resources to "accommodate" nurses danger allowance.

- There must be policies and protocols for non-psychiatric trained personnel caring for mental health care users in order to guide them on how to handle the mental health care users.

5.4 RECOMMENDATIONS

Recommendations are made based on findings of this study. These findings can be applied to the following areas:

Psychiatric nursing practice

1. The results of this study point to a need for non-psychiatric trained nurses to follow a holistic approach when caring for mental health care users. In the implementation of the nursing process, nurses need to use a theory that considers a client in totality, that is, body, mind and spirit as well as the external environment and patterns of interaction between the internal and external environment. An example of that theory is the theory of Health Promotion in Nursing.

2. It is clear from this study that the non-psychiatric trained nurses experienced a big challenge in caring for the mental health care users because patients were mixed and the nurses focused more on the medical patients especially because they had different feelings about mental health care users. Having a special ward for observations would help in the application of a holistic approach of care by these nurses.

3. The special unit must have full equipment (the blood gas machine) necessary for the 72 hour observation with ward staff trained and orientated to specifically care for the mental health care users on 72 hour observations. This will prevent the mixing of medical and mental health care users predisposing the mental health care users to other conditions and situations like tuberculosis and possible assault.

4. A reconstruction and transformation of attitudes of all in the clinical setting towards mental health care users for the promotion, maintenance and restoration of their mental health is necessary. The environment must be conducive for all parties, namely management, students, ward staff, doctors

and families. Orientation of relatives and workshops for all health professionals on expectations and policies would be of advantage.

5. Nurses working in this special ward should be granted a danger allowance. This is a specialized unit for psychiatric assessment and so therefore nurses are at risk. That being the case, the danger allowance would be granted as a form of incentive.

6. There must be a proper handing over of drugs between shifts. This will ensure drugs which are out of stock are ordered preferably by the day staff, promoting the availability of drugs at all times.

7. There must be a senior person to check the drug book on a weekly basis. This will help to ensure drug availability and facilitate the mobilization of resources correctly.

8. Protocols stipulating different types of psychiatric cases and their management must be displayed on the notice board of the unit to ensure that every ward staff member is updated on it.

9. Workshops must be organized to revive the professional philosophy of all individuals in patient care.

10. A train-the-trainers program developed and tested to teach communication skill can be useful in developing their own comfort level and communicating with psychiatric patients (Harms 2009:82).

11. The department could make use of simulations to practice and teach communication skills.

12. The use of a dedicated psychiatric emergency service may reduce the length of stay of boarding time for patients awaiting psychiatric care and improve safety and quality.

Psychiatric nursing education

The guidelines generated from the findings can also be considered in designing in-service programs and workshops or orientation training of non-psychiatric trained nurses caring for the mental health care users in all casualty/emergency departments of general hospitals. Nursing service and education must revisit the unit

to provide in-service education programs for empowerment of non-psychiatric trained nurses caring for mental health care users.

Nursing Research

The description of the research methods in the study included sufficient detail to ensure that they can be used in other studies. This is especially important because the nature of the methodology used in this study does not make generalization easy. Further research can be conducted on what brings about different attitudes in nurses when caring for mental health care users; studies about families living with a mental health care user, and comparison of experiences of psychiatric trained and non-psychiatric trained professional nurses during the 72 hour observations.

5.5 LIMITATIONS

This study was conducted in one listed hospital in the O.R. Tambo District using a small sample. Although the results may be generalizable to other hospitals where 72 hour observation is done, they may not be generalizable to other hospitals that have different resources. This study was conducted during intervals such as lunch time or off time. This led to the exclusion of a variety of participants who could not find time for interviews. Another limiting factor is that there were no male nurses interviewed. The number of male nurses is increasing but there was none available from the department. Owing to renovations, interviews were conducted in different private rooms and each locality may have influenced the interview differently.

Literature on the topic was available, but most of the studies were conducted in settings that were different to the one in which this study was conducted. The inquiry was conducted in a predominantly under-privileged region of the Eastern Cape. It is very likely that most of the studies may have been conducted in settings quite different from those in the Eastern Cape with reference to infrastructure, policies, administration and resources, all of which might have impacted differently on caring for mental health care users. Since this study was conducted in English as per participant's wishes, there were errors of tense which might have resulted in losing and distorting the originality of the participants' everyday life and there is a possibility it might have been expressed differently in the vernacular.

5.6 CONCLUSION

This study arose from observations that there were non-psychiatric trained nurses who cared for mental health care users on 72 hour observations and the researcher knew from experience that this situation was very stressful. The purpose of this study was two-fold: firstly, the exploration and description of experiences of non-psychiatric trained nurses caring for the mental health care users on 72 hour observation and secondly, the construction of guidelines for non-psychiatric trained nurses in mobilizing resources to facilitate the promotion, maintenance and restoration of mental health as an integral part of health.

The central questions posed for the study were: 1). What are the experiences of non-psychiatric trained nurses caring for the mental health care users during the 72 hour observations? 2). what are the guidelines that can be formulated to facilitate the promotion, maintenance and restoration of mental health as an integral part of health? A qualitative, explorative, descriptive and contextual research was carried out to answer these questions. Semi-structured interviews were conducted with non-psychiatric trained nurses caring for mental health care users. The results of the semi-structured interviews and field notes written during the interviewing stage suggested different themes and sub-themes.

Based on these results, guidelines were developed for the non-psychiatric trained nurses caring for mental health care users to mobilize resources for the promotion, maintenance and restoration of their mental health as an integral part of health. It can be concluded that the research questions were answered and thus the objectives of this research study were achieved. The central statement of the study has been supported.

The guidelines and recommendations suggested here are intended to empower the non-psychiatric trained nurses and others who come in contact with mental health care users when caring for them. In conclusion it can be said that this study has shown the experiences of non-psychiatric trained nurses caring for the mental health care users during 72 hour observations. The findings showed that the nurses need

assistance in their practice of promoting, maintaining and restoring patients' mental health as an integral part of health.

5.6 PROOF OF EDITING THE DISSERTATION

The dissertation was also taken to the research editor (See the attached annexure H).

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CONSENT FORM

<u>CONSENT FORM</u>

Perceptions of non-psychiatric trained nurses caring for Mental Health Care Users

Name and status of research participant (student, nurse)

Institutional affiliation………………………………

Contact…………………...address with telephone no s…………..

Date………………………………

Permission for research

I have read and understood the information sheet and I am aware that I can ask any questions about the research and receive satisfactory answers.

I know that the participation is voluntary and that I can withdraw at any time without giving a reason.

I agree to take part in the interviews and give my permission for voice recording this and the use of quotes, without my name being disclosed.

I understand that the data, might be looked at by the researcher's supervisors or peers for reviewing without my identity being revealed.

I agree to take in the research.

Name of the participant   Name of the researcher

………………………………….   ………………………………

TO THE PARTICIPANT

REQUEST TO CONDUCT RESEARCH

I, Dubo Siyabonga wish to conduct a research project entitled 'The experiences of non-psychiatric trained nurses caring for mental health care users on 72 hour observation in a listed hospital in the O.R. Tambo District' for a degree M Cur in psychiatric nursing science. The study will be done under the supervision and guidance of Dr Mbadi promoter of the department of nursing science, WSU.

The objectives of this research study are twofold:

1.To describe the experiences of non-psychiatric trained nurses caring for the mental health care users on 72 hour observations, and

2. To formulate the guidelines that can assist nurse in their practice of caring for these patients.

I want to invite you to participate in this research project.

After obtaining your permission, a phenomenological interview will be conducted for 45 to 60 minutes whereby you will describe your perception on caring for the mental health care users on 72 hour observations. Only one open-ended question will be asked of you during the interview and it is: 'Could you describe your experiences of caring for mental health care users during the 72 hour observations?" This interview will be voice recorded and transcribed verbatim for verification of findings by the researcher, independent coder and my supervisor.

Arrangements will be made with you once the permission has been granted by you as to the place where the interview will be conducted (at a place and time convenient to you). Research results will be made available to you on request. Participation in this study is voluntary and even during the course of an interview

you can withdraw at any time without penalty. You will not be paid for participation in this study.

In order to protect your name, I will undertake the following:

- To omit and disguise your name when discussing information pertaining to the study;
- To keep all raw data under lock when not in use;
- To ensure that no one except my supervisor, coder and psychiatric nurse concerned will have access to the raw data, and
- To leave you with my contact address in case you need to see me in connection with any matter arising from the study.

Your participation in this study has the potential of benefiting other nurses who are a similar situation. The direct benefit to you is that during the interview you will have the opportunity to verbalize your experiences of being exposed to 72 hour observations and have my individual attention for 45 to 60 minutes.

Signed at …………………………………. On this…………………………..day of…………………2014

PARTICIPANT

SIYABONGA DUBO (MR), RN

M.CUR (Psychiatric Nursing Sciences) student

DR MBADI IRENE, D.CUR

LECTURER, DEPARTMENT OF NURSING SCIENCES (WSU)

PROMOTER

INTERVIEW SCHEDULE

All participants were asked the same question at the beginning of the interview. I t was phrased thus: "Could you describe your experiences of caring for mental health care users on 72 hour observations?"

Mr S. Dubo

P/Bag X1

Mthatha

5117

Cell: 0832435497

Email: sdubo@wsu.ac.za

The Chief Executive Officer

Mthatha Regional Hospital

P/Bag X5014

Mthatha

5099

Date: 14/10/2014

Dear Sir/Madam

REQUEST TO CONDUCT A RESEARCH STUDY AT MTHATHA REGIONAL HOSPITAL IN THE O.R TAMBO DISCRICT

I am a Registered Nurse, currently registered for the Magister Curationis (Psychiatric Nursing Science).I wish to conduct a research study entitled 'the perceptions of non-psychiatric trained nurses caring for the mental health care users on 72 hour observations in a listed hospital' as a requirement for the degree of Master Curationis (Psychiatric nursing science). The study will be done under supervision and guidance of Dr Mbadi as the promoter in the Department of Nursing science.

The objectives of this research study are:

- To describe the perceptions of non-psychiatric trained nurses towards the mental health care users on 72 hour observations
- To describe the guidelines that would be formulated in order to help in the practice of these nurses.

For these objectives to be achieved it is necessary to collect data from these nurses caring for the mental health care users. The center and staff will be used to identify potential participants and to set up appointments for the researcher to interview the latter at places and times convenient to them. A letter to the respondents is also attached. Research results will be made available to your department on request.
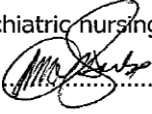
Participation in this research is completely voluntary and respondents have the freedom to withdraw at any time without penalty. Interviews that will be conducted with respondents will be audiotaped.

Confidentiality and anonymity will be ensured by not identifying respondent's names and audiotapes being destroyed after they have been transcribed. The benefit for the respondents in participating in this research is that they get the opportunity to tell their story regarding their perceptions on mental health care users.

I will gladly answer any further questions you may have on this project.
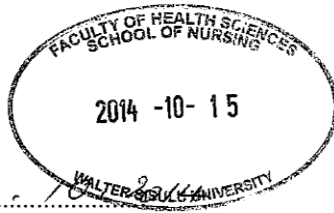

SIYABONGA DUBO (MR) RN

M.CUR (Psychiatric nursing science) STUDENT

SIGNATURE ....DATE... 14/10/2014.....

IRENE MBAD I (DR) RN, D.CUR

PROMOTER, NURSING SCIENCE DEPARTMENT

SIGNATURE.............................DATE......... 14 ....

2014 -10- 15

FACULTY OF HEALTH SCIENCES
SCHOOL OF NURSING
WALTER SISULU UNIVERSITY

APROVED / NOT APROVED.

BY MABUBELA

CO. MTHATHA REGIONAL HOSPITAL   DATE 2014/10/29

PROTOCOL FOR INDEPENDENT CODER

Dear Colleague

Please follow the steps below to analyse the data given.

1. Get the sense of the whole. Read through all of the transcriptions carefully. Perhaps jot down some ideas as they come to mind.

2. Pick one document (one interview) - the most interesting, the shortest, the one on the top of the pile. Go through it, asking yourself, what is this about? Do not think about the "substance" of the information, but rather its underlying meaning. Write thoughts on the margin.

3. When you have completed this task for several informants, make a list of topics. Cluster together similar topics. Put those topics into columns that might be arrayed as major topics, unique topics and leftovers.

4. Now take this list and go back to your data. Abbreviate the topics as codes and write the codes next to the appropriate segments of the text. Try out this preliminary organizing scheme to see whether new categories and codes emerge.

5. Find the most descriptive wording for your topics and turn them into categories. Look for reducing your total list of categories by grouping those that relate to each other. Perhaps draw lines between your categories to show interrelationships.

6. Make a final decision.

:WSU
Walter Sisulu University

FACULTY OF HEALTH SCIENCES
POSTGRADUATE EDUCATION, TRAINING, RESEARCH AND ETHICS UNIT

HUMAN RESEARCH COMMITTEE
CLEARANCE CERTIFICATE

PROTOCOL NUMBER	:	13/2014
PROJECT	:	THE EXPERIENCE OF NON- PSYCHIATRIC TRAINED NURSES WHO ARE CARING FOR MENTAL HEALTH CARE USERS ON 72 HOUR OBSERVATION IN A LISTED HOSPITAL IN THE O. R. TAMBO REGION.
INVESTIGATOR(S)	:	SIYABONGA DUBO
DEPARTMENT	:	NURSING
DATE CONSIDERED	:	23 SEPTEMBER 2015
DECISION OF THE COMMITTEE	:	APPROVED

N.B. You are required to provide the committee with a progress or outcome report of the research after every 6 months. The committee expects a report on any changes in the protocol as well as any untoward events that may occur at any time during the study as soon as they occur.

....
Dr T. APALATA
DEPUTY CHAIRPERSON

__14- 10 - 2015__
Date

DECLARATION OF INVESTIGATOR(S)
(to be completed in duplicate and one copy returned to the Research Officer at Office L311, 3rd Floor, Old Library Building, NMD Campus, WSU)

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Research Ethics Committee. I/We agree to a completion of a yearly progress report.

....
N. B. Please quote the protocol number in all enquiries.

Eastern Cape Department of Health

Enquiries:	Zonwabele Merile	Tel No:	040 608 0830
Date:	09ᵗʰ October 2014	Fax No:	043 642 1409
e-mail address:	zonwabele.merile@impilo.ecprov.gov.za		

Dear Mr S Dubo

Re: The perceptions of non-psychiatric trained nurses caring for mental health care users on 72 hour observations in the OR Tambo district

The Department of Health would like to inform you that your application for conducting a research on the abovementioned topic has been approved based on the following conditions:

1. During your study, you will follow the submitted protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health in writing.

2. You are advised to ensure, observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants.

3. The Department of Health expects you to provide a progress on your study every 3 months (from date you received this letter) in writing.

4. At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the Epidemiological Research & Surveillance Management. You may be invited to the department to come and present your research findings with your implementable recommendations.

5. Your results on the Eastern Cape will not be presented anywhere unless you have shared them with the Department of Health as indicated above.

Your compliance in this regard will be highly appreciated.

DEPUTY DIRECTOR: EPIDEMIOLOGICAL RESEARCH & SURVEILLANCE MANAGEMENT

Ikamva eliqaqambileyo!

3 Mapuzi Street
Sidwadwa View
Mathatha 5099

12 March 2016

To whom it may concern

This is to confirm that I did proofread Siyabonga Dubo's Master in Nursing (M. CUR) dissertation, THE EXPERIENCES OF NON-PSYCHIATRIC TRAINED NURSES CARING FOR MENTAL HEALTH CARE USERS ON 72 HOUR OBSERVATIONS IN A LISTED HOSPITAL IN THE O.R. TAMBO DISTRICT. The errors attended to were of various kinds and the following list exemplifies some of them: sentence construction, unclear meaning, punctuation, diction, repetitive constructions, overused and/or misused discourse markers, incorrect pagination, as well as inconsistent citations in-text and in the reference list.

Should you require any clarification, my contact details follow below:

Cell: 078 6182817

Email: Thabsndlovu@gmail.com

Sincerely,

Dr Thabisani Ndlovu.

BA Hons (UZ), MA (UZ), PhD (Wits).

INTERVIEW-001 R.N

KEY: R- RESEARCHER

I-INTERVIWEE

R: I am a student at Walter Sisulu University, engaged in a research project in Psychiatric Nursing. My topic is on experiences of non-psychiatric trained nurses caring for mental health care users on 72 hour observations. As I have explained to you before, I will request that we start the interview, and every information gathered here will be kept confidential. Nobody will have access to this information except the person who will be helping me with data analysis e.g. my supervisor. I may come back to you again later, if there are certain aspects of the interview that I don't understand so that I don't misrepresent or misinterpret anything that you have said. The interview won't take long, depending on the information you are giving. If you are no longer willing to continue with the study you are free to withdraw participation, you won't be victimized. I will ask one question, is there anything that you want to know?

I: No, there is nothing, you may proceed.

R. Could you describe your perceptions of caring for mental health care users during the 72 hour observations?

I: Mmhhhh….. There is a lot that I can say about that, you know I am not trained on psychiatric nursing but I am managing these patients.

R: What is that 'a lot' you are talking about?

I: These patients need rehabilitation to ensure that they are well organized concerning themselves.

R: What do you mean?

I: I mean these patients come here not knowing what they are sick of, some of them come with weapons and it is difficult to manage them because I am afraid. We

have different episodes of staff members who are being bitten by these patients. And it becomes difficult for me when I am to care for psychiatric patient because I do not trust them and I am afraid of what he/she will do.

R: What do you mean by "different episodes of staff being bitten?"

I: Yes, a doctor was fisted by a psychiatric patient and I am not happy concerning the personal hygiene, concerning the risk that we are taking as our safety is compromised. Because sometimes we tend to run out of drugs in this hospital and you find that patients become violent.

R: And then how do you manage patients when you do not have drugs?

I: I just call a security [guard] so that we restrain the patient. And we are not supposed to restrain patients, but how do you start to give medication to a violent patient? These patients are also dangers to other medical patients, because some are bedridden they cannot run whilst there is a violent patient and restraints are needed to protect other patients.

R: So you use restraints for what?

I: We use restraints when we give medication to a violent patient or when the patient is still violent and still waiting for the medication to take its course [have effect] on a violent patient especially that patients are mixed with medical patients.

R: Which drugs are you referring to for example?

I: its haloperidol injection and lorazepam injection.

R: Oh ok, they are mixed with other medical patients?

I: Yes, they are and as a result we focus more on the medical patients because it's them that are in bigger numbers and at least we know what to do when we are nursing them, unlike psychiatric patients that we are not oriented about. And we don't have space for them, they just sit in the passage whilst they are waiting for blood results. And this is when some get lost or abscond because this ward is not

conducive for this observation, because patients can get up being mental cases and end up catching up other infections like PTB.

R: So what can be done to solve this?

I: There must be a separate ward that will be suitable for 72 hour observation and there must be trained nurses who care for them. And we need orientation and workshops on how to manage psychiatric patients because we are not supposed to choose patients but treat them equally, but how to treat them for something that you have not been trained to do? We need workshops about all types of patients that are presenting in casualty so that we can be able to even answer to our juniors when they are asking some questions. This leads us to be happy at work because sometimes you are afraid to answer because you are not sure of your answer.

R: Is there anything else that you would like to say?

I: Yes, we experience a big problem of relatives who become aggressive when they are explained on what is expected of them during the 72 hour observation and sometimes we fail to answer some questions they have. That is why we are really in need of these workshops especially the staff nurses because they are bedside nurses and they always deal with relatives of patients and we need this because we are exposed to mental cases on a daily basis.

R: Is there anything more?

I: No, it's just that I am hoping that this study will help us in this department because we not happy at all about nursing these patients.

R: Thank you very much for your time, I will give the report of the project because I also got the permission for the Chief Executive Officer of the hospital, I will also furnish her with the report.

I: Does each individual get a report because you said you would not write my name?

R: I know, the people I interviewed.

I: Are you going to evaluate my interview only?

R: No, but jointly for the topic: Thank you very much.

:WSU
Walter Sisulu University

WALTER SISULU UNIVERSITY
DIRECTORATE OF POSTGRADUATE STUDIES

MANDATORY CONSENT FORM: ELECTRONIC THESES & DISSERTATIONS (ETD) AND PLAGIARISM REQUIREMENT (For postgraduate research outputs from 2009 September)

TEMPLATE FOR THE STUDENT AND SUPERVISOR CONSENT FOR PUBLICATION OF ELECTRONIC RESEARCH OUTPUT ON INTERNET AND WSU INTRANET

FACULTY: _____

QUALIFICATION NAME: _____   ABBREVIATION: _____   YEAR: _____

STUDENT'S FULL NAME: _____   STUDENT NUMBER _____

TYPE OF RESEARCH OUTPUT: RESEARCH PAPER/MINI-DISSERTATION/DISSERTATION/THESIS (TICK ONE)

TITLE OF THE RESEARCH OUTPUT: _____

CONSENT: I HEREBY GIVE MY CONSENT TO WALTER SUSULU UNIVERSITY TO PUBLISH MY RESEARCH OUTPUT FOR THE QUALIFICATION ABOVE ON THE WSU INTRANET AND INTERNET. I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE, THERE IS NO PLAIGARISM IN THE RESEARCH OUTPUT AS SUBMITTED. I HAVE TAKEN REASONABLE CARE TO ENSURE THAT THE RESEARCH OUTPUT MEETS THE QUALITY LEVEL EXPECTED FOR THE PRESENT QUALIFICATION LEVEL BOTH IN TERMS OF CONTENT AND TECHNICAL REQUIREMENTS. I FULLY UNDERSTAND THE CONTENTS OF THIS DECLARATION.

_____   _____
SIGNATURE OF STUDENT   DATE

ENDORSEMENTS BY:

SUPERVISOR:

FULL NAME: _____   SIGNATURE: _____   DATE: _____

CO-SUPERVISOR(S):

1   FULL NAME: _____   SIGNATURE: _____   DATE: _____

2.   FULL NAME: _____   SIGNATURE: _____   DATE: _____