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Faculty of Community and Health Sciences

School of Nursing

Title of Thesis

Exploration of nurses' experiences of the assessment and management of patients at risk of absconding from an acute psychiatric ward in the Western Cape

Name of candidate: Fikile Nelson Malgas

Student Number: 2529611

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Supervisor: Dr M. Bimerew

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Abstract

Unlawful absence of patients from the acute psychiatric ward increases concern on the part of the professionals responsible for their care. Patients who abscond from psychiatric hospitals represent a risk of potential harm to patients or the general public. Consequences of absconding may include physical harm and prolonged treatment time, as well as considerable economic cost to the family and government. The aim of the study was to explore and describe the nurse's experiences of assessment and management for patients at risk of absconding from an acute psychiatric ward in the Western Cape. A qualitative approach using an exploratory descriptive design was applied to conduct this study. The target population was mental health nurses working in acute psychiatric wards where patients were at risk of absconding. A sample of ten (n=10) mental health nurses was purposively selected to participate in the study. Semi-structured interviews were used to collect the data from participants. Data collection continued until data saturation was reached (until no further new information emerged). Data was analysed manually by coding, categorizing and identifying similar patterns. Trustworthiness of the study was ensured through addressing the confirmability, transferability; credibility and dependability. Ethics approval was obtained from the University Research Ethics Committee and Ethics Committee of the Department of Health and the selected psychiatric hospital. The ethical principles of the right to self-determination, withdrawal from the research study, privacy, autonomy and confidentiality, fair treatment, protection from discomfort and harm, and obtaining informed written consent were adhered to. Three themes emerged from the data: risk assessment, risk management, and increased observations. The results of the study was discussed with relevant recent literature evidence. The qualitative research is limited to few study sample size, and the results cannot be generalized to other similar population.

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Keywords:

Absconding

Acute psychiatric ward

Experiences

Inpatients

Risk assessment

Risk management

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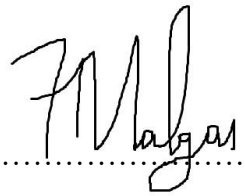
DECLARATION

I declare that "Exploration of nurses' experiences of assessment and management of patients at risk of absconding from an acute psychiatric ward in the Western Cape" is my own work, that it has not been submitted for any other degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Signed: 

Name: Fikile N. Malgas

Date: 24/04/2017

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God bless you all!

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Contents

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WESTERN CAPE

http://etd.uwc.ac.za

UNIVERSITY of the
WESTERN CAPE

http://etd.uwc.ac.za

CHAPTER FOUR: RESULTS OF THE STUDY

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UNIVERSITY of the
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TABLES

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CHAPTER ONE

ORIENTATION TO THE STUDY

1.1 Introduction

This chapter presents the research problem, research question, aims, objectives and significance of the study. The study is an exploration of nurses' experiences of the assessment and management of patients at risk of absconding from an acute psychiatric ward.

1.2 Background information

Unlawful absence of patients from the acute psychiatric ward increases concern on the part of the professionals responsible for their care. When a patient absconds nurse need to understand how it happened, which can lead to members of the team being blamed. The most common place to lay blame is with the nurse observing the patient or observing the door (Moore & Hammond, 2011). Even though there has been interest in this topic for many years, little is known about why patients abscond. Why and how patients abscond from acute psychiatric wards in developing countries, for example South Africa, may be different from in the mental hospital setting in developed countries (Khisty, Raval, Dhadphale, Kale & Javadekar, 2008). In developing countries like South Africa there is a shortage of nursing staff in the acute psychiatric wards.

The absconding of patients from psychiatric hospitals is also a clinical problem that can place patients at risk of harm to self as well as to other patients and nursing staff. Contributing factors to an increased risk of absconding that are related to the person concerned include demographics and a prior history of violence and aggression, often with a diagnosis of schizophrenia. A second category of factors that are external to the person include the clinical

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culture and treatment provided. There is a risk of suicide and of death due to exposure to drug abuse, which provokes anxiety among the nursing staff (Allen, 2009).

Hiring of agency nurses is not a solution since they do not know the patients, and this may cause a rise in frustration and risk of absconding among patients because they do not have enough time to talk to nursing staff. The concept of risk in mental health care can refer to a number of issues, including risk of harm to self and others, risk of substance use and risk of absconding (Arya & Nicholls, 2005). Such risks are taken for granted as aspects of mental health nursing; it is perhaps because of this that acknowledgement and use of risk assessment by mental health nurses in informing clinical practice is under-researched (Muir-Cochrane & Mosel, 2008).

In particular, nurse's perceptions of risk assessment and management of patients' risk of absconding (leaving the hospital wards or grounds without permission) have been given little attention (Stewart & Bowers, 2011). This is despite the fact that absconding has potentially harmful outcomes, including non-compliance with medication and self-neglect. Nursing staff have the responsibility of assessing and managing whether a patient is likely to abscond while they are in the psychiatric ward. Mental health nurses have to observe potential indicators for absconding inpatients while they are hospitalised in an acute psychiatric ward, and thus ensure the safety of patients, staff and visitors.

Absconding or unauthorised absence of patients from acute psychiatric wards has been recognised as a problem (Bowers, Simpson & Alexander, 2005). The risk associated with absconding highlights the need to develop tools and strategies to identify potential absconders (Davis, Bowers, Jarrett, Clark, Kiyimba & Mcfarlane, 2014). Four areas of risk are associated with absconding: risk of suicide and self-harm; risk of aggression and violence; risk of self-

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neglect or death through exposure to substance abuse; and risk of loss of confidence in the service and damage to the ward environment (Moore & Hammond, 2011).

The limited research that is available suggests that the emphasis within policy and literature on risk management around risk to self and others is reflected in the way that nurses conceptualise risk (Briner & Manser, 2013). In the majority of research studies on clinical risk management in mental health, which involve qualitative study of main risks and review of related organisational management practices, nurses tended to define risk as something negative and harmful, and as a phenomenon that is located within the individual and that has to be assessed, managed and prevented (Woods, 2013).

Consequently, as opposed to viewing risk in a complete and positive way, it was conceptualised primarily as harm to self (suicide, self-harm) or to others (violence) (Woods, 2013), with little emphasis on risks posed to service users of the mental health system or the wider community. Indeed, only one study was located in exploring nurses' experiences or practices in relation to other types of risk. Of in-patients 23%, (n=90) absconded while they were granted leave from the ward and 60%, (n=`120) of cases of absconding occurred while patients were in the wards, which is confirmed by studies that show significant proportions of inpatients absconding from the ward over a six-month period (Gunstone, 2013).

Absconding from psychiatric hospital wards (leaving without permission) remains an important health issue with social, economic, and health costs. The mean rate of absconding has previously been documented as 12.6 per 100 patients, with a range of 2–44 (Bowers, 2009). Personal observations and hospital records for quality assurance have shown that there were five incidents of patients absconding among 30 inpatients while nine attempted absconding from the psychiatric hospital in this study for the past six months (Department of health, 2016).

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Common aims for to keep the exit doors of psychiatric wards locked, as indicated by ward managers, are to prevent patients from escaping, and according to legislation are to provide patients and others with safety and security, to prevent importation and unwelcome visits, and because of nurses' need of control (Haglund, Van der Merwe, Von Knorring & Von Essen, 2007, p. 52). Mental health professionals also see many serious disadvantages of locking ward doors, for instance, the fact that it makes patients feel confined and isolated, creates a non-caring environment, makes staff power obvious and forces patients to adapt to other patients' needs, as well as causing extra work for staff (Haglund et al., 2007).

Nurses are involved in managing the risk of patients leaving hospital while acutely ill, as well as dealing with the consequences of an absconding event. However, in spite of their key role, few studies have explored nurses' experiences of patient secondment. The last decade has seen an increasing focus on risk assessment, with risk containment and minimisation in the delivery of current mental health services internationally (Raven & Rix, 2007; Crowe & Carlyle, 2008; Kettles, Moir, Woods, Porter & Sutherland, 2009; Ashmore, 2008).

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Nurses are therefore required to participate in assessment of risk and endorse risk management techniques on a daily basis (Buchanan-Barker & Barker, 2005). Risk assessment processes involve concern about real and observed risk to patients and others, which includes factors such as current or past behavior and mental state (Kettles et al., 2007). This assessment results in the identification of at-risk patients, which is used in conveying a care plan aiming interventions towards those in need. There has been extensive discussion and debate on the correctness of risk assessment in foreseeing the risks that a patient actually poses. Actuarial approaches are reported to be better than clinical judgement alone, while structured clinical judgement may be the best method because it allows for the flexibility to consider case-specific factors (Doyle & Dolan, 2011).

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Risk management involves actions to report and minimise the assessed risk. It may include the use of therapeutic support, time out, sedating medication, as well as containment methods such as seclusion, restraint, increased observation levels and locking of ward doors or parts of wards (Briner & Manser, 2013).

Assessing and managing a patient's risk of absconding occupies a noticeable position within mental health nursing worldwide, and the need to anticipate and prevent absconding can create anxiety in nursing staff (Muir-Cochrane, 2006). This is because attempts to abscond could possibly be made by any patient within a mental health institution in the acute psychiatric wards. (Moore & Hammond, 2011), and may on occasion lead to serious consequences (Bowers, 2009). Absconding rates vary widely in the international literature, with rates of between 25% and 34% of all psychiatric admissions reported (Meehan, Morrison & McDougall, 2010; Muir-Cochrane & Mosel, 2008). In South Africa, in one of the psychiatric institutions in Johannesburg, 97 patients absconded 108 times during the study period (7 having absconded more than once), the absconding rate being 7.83%. The typical absconder is a single unemployed male in his early 30s, known to the psychiatric services, diagnosed with schizophrenia and co-morbid substance use, and is more likely to be a forensic patient not returning from an official leave of absence (Alaszewski, 2005).

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An Australian study of three acute care psychiatric wards found that over 10% of compulsorily hospitalised patients absconded at least once during their admission (Mosel, Gerace & Muir-Cochrane, 2010). A number of approaches have been proposed to decrease and manage patients' risk of absconding, including locking ward doors, increased availability of short-term accompanied leave for patients and decreased ward numbers (Ashmore, 2008).

1.3 Problem statement

Absconding of psychiatric patients is a common problem for acute psychiatric wards in developing countries, including South Africa. The frequency of absconding reported in the

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literature varies due to differences in how the behaviour is measured and defined (Wilkie, Penney, Fernane & Simpson, 2014). Even though the number of absconding patients and problems caused by them are not recorded accurately, from personal observation absconding patients may harm themselves or other people while away from the psychiatric hospital. Absconding patients also cause anxiety and frustration to the healthcare providers (Bowers, 2009). Common emotional reactions of nurses caused by absconding patients include fear, anger, concern and anxiety together with a sense of their failure to prevent this event (Bowers, 2009). A great deal of work is necessary on the part of both psychiatric staff and the police in order to complete reports, and occasionally to assist the patient to return to hospital (Meehan et al., 2010). The consequences of absconding include prolonged treatment time and considerable economic cost to the family and Government.

When a patient absconds it is difficult to carry out assessments and observations as to who is to blame and how such incidents might be reduced (Stewart & Bowers, 2011). Once a patient has absconded most nurses' look for an explanation, which can lead to blaming other members of the team. Most studies focus on the socio-economic and clinical consequences of absconding; however, not much is known about the experiences of those nurses dealing with the absconding patient on a day-to-day basis, and how absconding risk assessment and risk management has been conducted in the Western Cape, South Africa.

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1.4 Research question

The research question in this study is as follows: What are nurses' experiences of the assessment and management of patients at risk of absconding from an acute psychiatric ward in the Western Cape?

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1.5 Aim of the study

The aim of the study is to explore and describe nurses' experiences of risk assessment and management of patients at risk of absconding from an acute psychiatric ward.

1.6 Objectives of the study

- To explore and describe nurses' experiences of risk assessment of patients who are at risk of absconding from an acute psychiatric ward.
- To explore nurses' experiences of the use of containment measures for the management of patients at risk of absconding from an acute psychiatric ward.
- To explore nurses' experiences of the use of increased observation measures for the management of patients at risk of absconding from an acute psychiatric ward.

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1.7 Significance of the study

Absconding from the psychiatric hospital is the key patient safety issue for persons with mental illness, because of these persons' potential increased risk of harm to self and others. The results of this study could inform decision-making bodies for developing strategies that may help to prevent patients from absconding. It is further hoped that the results of this study yield information that may assist healthcare providers in identifying ways to reduce absconding, and improving the quality of care provided to patients in psychiatric facilities.

1.8 Operational definitions

Risk assessment: The systematic processes of evaluating the potential risk that may be involved.

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Operational definition: The way the nurses understand and practice assessment of patients at risk of absconding.

Absconding: When a person in care cannot be located within the treatment unit and their whereabouts are unknown.

Operational definition: Unauthorised absence of a patient from the ward.

Risk management practices: The practice of identifying potential risk in advance, analysing this risk and taking precautionary steps to reduce the risk.

Operational definition: The way nurses understand and practice management of an absconding patient in acute psychiatric wards; chemical and physical restraint, namely administering psychotic medication or using seclusion.

Inpatient: A patient being admitted to a psychiatric hospital while under treatment.

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Operational definition: Care of patients whose condition or mental illness requires admission in a psychiatric hospital.

Acute psychiatric ward: A psychiatric health facility that is licensed to provide high-care inpatient services.

Operational definition: Ward for admission of patients who require short-term hospital care to treat their mental illness and prevent them from causing harm to themselves and others.

Vigilant: a state of watchful attention, of maximal physiological and psychological readiness to act and of having the ability to detect and react to danger or harm.

Operational definition: Nurses need always to be careful to notice things among patients, especially possible harm.

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1.9 Conclusion

In this chapter the research problem and aims and objectives were described. Most importantly the research question which supports the study was introduced and clearly defined, and the motivation for wishing to carry out this particular study was also outlined The study is made up of the following chapters:

Chapter One sets out the background of the study, presents the research problem, research question, aims, and objectives and outlines the significance of the study. The concepts of assessment and management for patients at risk of absconding and its relevance to nursing is introduced, as are the reasons for undertaking this project.

Chapter Two discusses the literature review to locate the study in both the international and local context, and lays the foundation for the study. A general background on the experiences of nurses is provided, and the chapter proceeds to explore the experiences of nurses of the assessment and management of patients at risk of absconding from an acute psychiatric ward from previous studies. The prevalence of mental disorders is also discussed. In addition, literature relating to acute psychiatric wards, mental health care users (MHCUs) found in these units and their clinical picture are presented. Gaps in the literature are identified and the foundation for the study is laid.

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Chapter Three discusses the methodology that was used to investigate the research problem and answer the research question posed in this study. Qualitative research with an explorative and descriptive research design was employed to conduct the study. An overview of the qualitative research methodology is discussed, and the methodological framework which was followed in reaching the conclusions of this study is outlined. Sampling, recruitment of participants, data collection and analysis methods are described.

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Chapter Four presents the results of the study. These are presented by means of themes that emerged during data analysis and interpretation involving three stages (Sarantakos, 2005; Barry& Elmes,2005; Leininger, 2006). The themes presented and direct quotations from participants are used to describe the results and the overall experiences of nurses of assessment and management for MHCUs at risk of absconding from an acute psychiatric ward.

Chapter Five discusses the results in detail and compares them with national and international studies. Each theme is discussed in detail and the link between the themes is presented together with sub-themes. A detailed description of nurses' experiences of the assessment and management of patients at risk of absconding from an acute psychiatric ward is provided through the themes that emerged.

Conclusion discuss the findings shows that the nurses' experiences mentioned in the interviews provide guidance on how to deal with the risk of absconding. The next chapter will discuss the limitations, recommendations and conclusion of this study.

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Chapter Six provides a summary and recommendations to address some of the critical challenges that emerged from the experiences of nurses working in an acute psychiatric ward.

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CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter discusses relevant literature on nurses' assessment and management of patients who abscond from acute psychiatric wards. The engagement with literature is justifiable due to the nature of the study being semi-structured interview, and thus the use of the literature guided the process of creating a structured interview guide. This chapter contextualizes the study by reviewing the relevant literature. It gives a general background on the experiences of nurses is provided. Furthermore, the chapter continued to explore the experiences of nurses in previous studies by using a search database e.g. google scholar, academic search complete (EbscoHost), E Journals and psychiatric articles. Keywords were used such as absconding, risk assessment, risk management and acute psychiatric ward. During admission patients presenting and considered as high risk must be seen and given high triage priority for assessment by professional nurses so that a review can be undertaken immediately. A professional nurse plays a role in the assessment of high-risk patients, prevention and management strategies. Each member of the nursing staff should know his/her role including hospital procedures for defining when a person is considered at risk, as well as prevention strategies and management for patients at risk of absconding from an acute psychiatric ward. The literature review was discussed under the following headings: risk assessment of an absconding patient, contributory factors to absconding, care planning, therapeutic relationships and prevention of absconding, risk management, identification of high risk patients, staff training and conclusion.

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2.2 Risk assessment of an absconding patient

There has been an increasing focus on risk assessment and risk management in the delivery of mental health services internationally (Raven & Rix, 2007). Nurses are required to engage in the assessment of risk and endorse management strategies on daily basis (Buchanan-Barker & Barker, 2005). Risk assessment processes involve the consideration of actual and perceived risk to patients and others, including consideration of factors such as current or past behaviour and mental state (Woods & Kettles, 2009). Risk assessment can be conducted using clinical judgement or actuarial risk assessment approaches using instruments designed specifically for assessing risk, or a grouping of the two which is termed 'structured clinical judgement' (Woods, 2013).

There has been consideration and discussion of the accuracy of risk assessment in predicting the risks that a patient actually poses. Actuarial approaches are reported to be better than clinical judgement alone, while structured clinical judgement may be the best approach because it allows for the flexibility to consider case-specific factors (Doyle & Dolan, 2011b). In short, absconding is seen as a behaviour needing intervention because of the perceived association with risk while the person is absent (Bowers et al., 2006). In terms of social history, absconding is a problem because it threatens the reasoning for confinement as being for the protection of the person and others (O'Driscoll & Walmsley, 2010).

Nurses believe that every patient arriving at the ward should be assessed for potential risk of absconding because how would their risk be known if it hasn't been assessed (Kettles et al., 2007). However, while all nurses agreed that assessment of a patient's risk should be made as soon as possible after they have arrived on the ward, they indicated that this assessment is not a clear-cut process as every case is different (Braun & Clarke, 2006). Interestingly, despite nurses recognising the dynamic and complex nature of risk assessment, they state that assessing

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risk of absconding involves significant clinical judgement, particularly in terms of what information and knowledge are used in determining risk of absconding, and how risk assessment used in nurses' daily practice. The study also explores the nurses' experiences of assessment and management of patients at risk of absconding, including strategies or tools currently used and their perceived effectiveness and nurses' experience in using these (Gerace, Curren & Muir-Cochrane, 2013).

During initial and resulting ongoing assessment written documentation must include a full risk assessment to be completed on admission and went through as appropriate, depending on clinical need. It is the responsibility of the admitting professional nurse to ensure this is undertaken and documented. It must be identified whether the service user is at high risk of absconding, and what the potential or actual risks are if the service user were to successfully abscond or to go absent without leave; this must be documented, including who is at risk – the service user or others (Mosel et al., 2010). The details of the risks in the case of the service user absconding or being absent without leave, names and phone numbers of whom to contact, including family details, and potential use of other agencies, including the police, need to be noted. Relevant timescales should be included: for example, is the risk immediate, as well as factors that might increase or decrease risk. Specific interventions should be documented to prevent the service user from absconding from the ward environment; such interventions should influence decisions about the level of security required, and appropriateness of the ward environment and staffing levels. A full risk history, risk factors (potential and actual) and all potential and actual risks must be communicated to the full multidisciplinary team (Stewart & Bowers, 2011).

There is therefore a challenge in the practical operation of the balance between a focus on the risk that a patient is seen to pose (particularly in areas where risk to others and self is involved),

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and development of "a respectful and considered therapeutic relationship which assisting the patients to achieve a sense of ownership and responsibility for their mental illness, treatment and risk management" (Kelly, Simmons & Gregory, 2010, p. 208).

In a study on mental health nursing assessment, MacNeela, Scott, Treacy and Hyde (2010, p. 1298) suggested that psychiatric nurse's assessment practices are influenced more by experiential, understood knowledge than by formal decision aids and assessment models". These authors proposed that this is at odds with concerns in health care for transparency, accountability, and quality assurance.

2.3 Contributory factors to absconding

Many patients who leave care report leaving doing so for reasons such as boredom; fear of other patients; lack of privacy; lack of meaningful recreation and leisure; feelings of confinement (which may be related to the quality of the care environment, e.g. overcrowding); perceived household responsibility (e.g. the need to get home to finish tasks or take care of a pet – tasks perceived to be more important than their care); and isolation from relatives and friends (Bowers et al., 2007).

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In addition to these conditional reasons for absconding, there are two categories of factors that have been identified as contributing to an increased risk of absconding. The first category of factors is related to the person concerned, such as demographics or prior history of violence and aggression. The second category of factors is external to the person and includes the clinical culture and the treatment provided, where no risk assessment tools are being used to predict absconding. When reflecting on their practice, nurses were able to identify several markers for assessing the risk of absconding (Stewart & Bowers, 2011).

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These revolved around the consideration of a patient's past history and current clinical presentation. Clinical judgement was used to weigh up all potential risks to ascertain a change in factors such as the patient's mental state, and suicidal or psychotic features that nurses believed would assist in determining the patient's likelihood of absconding. As Beghi, Peroni, Gabola, Rossetti and Cornaggia (2013, p.12) put it:"It's like a join up of a lot of features, if you get the risk score that's raising illness or there's a change in behaviour or you just get a sense in your unconscious that something's wrong, that informs you as to whether or not there's something going on (p.15)."In nurses' experiences the most main markers came from drawing on a patient's past history. Mainly this involved whether they had absconded before or had previously expressed frustration regarding their hospitalisation (Bishop & Ford-Bruins, 2011). There was reflection among the nurses that signs and patterns of a patient's desire to leave are recognised from past admissions. Understanding past admissions allowed staff to get to know the patients and their habits, which enabled them to make judgements as to whether the patient was likely to abscond (Bishop & Ford-Bruins, 2011).

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If someone is found to be susceptible to abscond after numerous admissions, nurses thought it should be taken it into account; however, it was also noted that history is used carefully as every case has to be considered at the exact moment that it is happening (Kelly, Simmons & Gregory, 2010). It was also recognised that presentations change between admissions, and can even vary throughout the day. As a result, nurses reported that they do not rely solely on the patient's history; but also acknowledge the vital importance of current clinical presentation in making an assessment (Crowe & Carlyle, 2008).

The main areas identified when looking at a patient's current presentation included the content of their conversation and their behaviour (Woods, 2012). A specific focus was on whether the patient was pacing, appeared to be hyper-vigilant, severely distressed, agitated, tormented,

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expressing suicidal ideation or simply asking if they can go to the shops. Other predictive factors included the patient's level of functioning, and their level of ability to comprehend, understand and comply with the admission process (Woods, 2012).

The nurses like to meet with the patient as soon as practicable to assess their mental state, and feel that fairly quickly they can pick up whether they are at high risk for absconding or for self-harm through their level of illness, or a risk to themselves through misadventure (Martin, & Thomas,2014).Despite identification of the use of these assessment tool in determining risk, and in most cases seeming individual choice of the nurses as to their relative importance, no clear agreement is in place as to what information was of the most benefit in making the assessment. As a result, registered nurses question the accuracy of their assessments (Gilburt, Rose & Slade, 2008).

Clinical risk factors related to an increased risk of absconding include those related to diagnosis and symptom severity. While all persons with mental health issues are at risk of absconding, that risk is understated in persons who have been diagnosed with schizophrenia.

Schizophrenia tends to be the most common diagnosis associated with the risk of absconding, followed by borderline personality disorder. Persons with schizophrenia may attempt to abscond because of positive symptoms such as delusional thoughts or command hallucinations, and persons with borderline personality disorders may abscond as an act of defiance against care provision or rules in the treatment environment (Whitehead & Mason, 2006).

2.4 Care planning

The following factors must be considered as part of a patient's therapeutic care plan: absconding should only be prevented where there are high-level safety risks and the person does not respond to diversion or distraction and regularly or constantly seeks to leave the

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designated clinical area. Wandering should only be contained where the environment is an actual risk for the person or if the person is becoming distressed and exhausted or their health is adversely affected (Bowers, Simpson & Alexander, 2005).

A baseline cognitive assessment must be recorded, and in most instances this will be the Abbreviated Mental Test Score (Arya & Nicholls,2005). A detailed Mini-Mental State Examination is recommended, a patient assessment tool that should be completed on admission, repeated and regularly reviewed to identify the patient's risk of absconding. Patients at risk of absconding should be nursed in a high observation area within the ward area where possible; it should be ensured that they are placed away from main thoroughfares and exits and that ward door security alarms or locks are used where fitted (Bowers, 2009).

Ashmore (2008) state that in case of when the patient is sensitive to over-stimulation from noise and light levels, then a quieter area for keeping the patient should be considered, ensuring that ward doors are always closed; such a simple physical barrier can prevent absconding from a psychiatric ward. The mental health care user should be checked on a regular basis; the registered nurse in charge must assess the level of supervision and the patient must be checked at least every 30 minutes. However, following risk assessment there may be times when the patient requires continuous supervision. The nurse in charge is responsible for delegating other nursing staff to be responsible for this duty during a shift (Dolan & Doyle, 2011a).

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2.5 Therapeutic relationships and prevention of absconding

Strategies that may help prevent absconding and/or missing patients include establishing strong therapeutic relationships; providing care that is culturally responsive; using person-centred approaches to care; and the minimisation of the restrictive feel of the care environment (Muir-Cochrane & Mosel, 2008).

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Building rapport and establishing and sustaining a strong therapeutic relationship begins in the first moments of contact between the clinician and the person, and continues throughout the assessment and care process. This rapport is particularly important since most absconding behaviour occurs early in the treatment process, typically in the first few days to weeks of an admission to hospital (Dolan & Doyle, 2011b). Strategies for building rapport can include asking the person how he/she wants to be addressed; providing the person with an explanation of your role and the purpose of the assessment, which will minimise feelings of uncertainty and anxiety; listening empathetically and attempting to understand his/her experience and life goals; and taking the time to consider the person's story and hear their perspective of their needs (Cox, Hayter & Ruane, 2010). It is also important to assess the person's strengths, and to meet them in a comfortable and private environment (Cox et al., 2010).

Policies and approaches that support safety by preventing absconding need to be executed and imposed consistently among all inpatients on the unit. For example, a strategy could be developed to offer nicotine replacement therapy for inpatients who are not able to leave the treatment unit and threaten to leave. Mental health institutions should take care not to respond to pressures in this context with negative responses, corrective actions, or punishment. Instead, these threats should be viewed as an opportunity to discuss the MHCU's reasons for wanting to leave care, possible solutions to help the MHCU remain safely in care, and potential outcomes that the patient may encounter upon leaving (for example, risk of harm to self) (Muir-Cochrane, Mosel, Gerace, Esterman & Bowers, 2011).

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2.6 Risk management

Risk management involves actions to address and minimise the assessed risk. This may include the use of intensive support, time out, sedating medication, as well as containment methods

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such as seclusion, restraint, increased observation levels and locking of ward doors or parts of units (Briner & Manser, 2013).

Nurses are directly involved in managing the risk of patients leaving hospital while acutely unwell, as well as dealing with the implications of an absconding event. The nurses' perceptions of and insight into the patient's risk determined the type of management practice implemented in acute psychiatric wards (Grotto, Gerace, O'Kane, Simpson, Oster & MuirCochrane, 2014). Nurses also identified providing emotional support as a way to calm patients, as well as family involvement prior to the implementation of containment strategies. However, nurses openly stated that the support strategies identified were often only used until a more 'appropriate' strategy could be executed, and this generally involved the use of more restrictive methods (Bowers, 2009).

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Increased observation was the most common approach discussed, and locked doors and the use of chemical restraint in the form of extra medication were mentioned as methods of containment currently used. This was perceived to be a helpful measure for nurses, as it allowed them to know where a patient that was perceived to be at high risk was at all times (Nijman, Bowers, Haglund, Muir-Cochrane, Simpson & Van der Merwe, 2011).

It also provided a positive reflection on the nurses, because they were seen to be supportive of patients, although "quite a few patients see it as a positive thing that people are checking on them if they're still there" (Gordon, 2012, p. 187). The desire to lock the ward was discussed at length; this was due to the perception that it was the best method available to contain those patients at particularly high risk of absconding (Haglund et al., 2007).

2.7 Identification of high-risk patients

Day and night nurses and healthcare assistants have to be actively involved in identification of the group at high-risk of absconding (Hearn, 2013). This process must be systematic and

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methodical, focus on one patient at a time and leave sufficient space for team discussion and collaboration. Nursing staff should document the process in the patient's notes, and place an appropriate symbol on the ward whiteboard beside high-risk patients' names. Bowers, Jarrett and Clark (2010) state that a record of absconding must also be kept, since accurate records help identify the time and circumstances around absconding, and highlight those patients at most risk of absconding again.

2.8 Staff training

Education regarding the effects of absconding and prevention should be ongoing for mental health care nursing staff. Mini absconding reduction sessions lasting 15-20 minutes can occur on the ward, and are a valuable educational opportunity that will have benefits beyond the anti-absconding intervention, the findings of the study by (Sawyer, Green, Moran, & Brett, 2009). These could include case studies and problem-solving sessions, Muir-Cochrane and Mosel (2008) report that the anti-absconding intervention should be summarised in a self-training package/workbook and discussed at the weekly mental health hospital services managers' meeting. In Muir-Cochrane and Mosel's (2008) experience, these initial meetings were facilitated the spreading of information to ward nursing staff. The intervention was consequently discussed at length in staff meetings in terms of the pilot and the rationale including the success of its implementation in London in relation to a significant reduction in patient absconding rates. Staff were given protected time, incorporated into their ongoing mandatory training requirements, over a specified period of eight weeks to enable individual achievement of the workbook completion and full compliance by all staff. This enabled staff to have a chance to raise possible concerns or questions and to provide clarity (Bowers, 2013).

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2.9 Conclusion

Chapter Two discussed literature on risk assessment and management for patients absconding from an acute psychiatric ward. It was reported that a reliance on clinical judgement alone for risk assessment was ineffective. The nurses themselves recognised that current methods of risk assessment were inadequate, highlighting the need for a structured guide to be used in combination with clinical judgement.

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CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter provides a detailed description of the methodology employed in this study, including the qualitative research approach, research setting, research design, population and sample, data collection method, interview guide, pilot study, data collection process, data analysis, rigour of the study and ethical principles followed while conducting this study.

3.2 Qualitative research approach

A qualitative research approach was chosen to conduct the study in order to gain a deeper understanding of the meaning that the participants bring to the study and to elicit these. A qualitative approach is recommended when little is known about the phenomenon, which allows the researcher to identify, explore and describe phenomena that are poorly understood in that particular context (Botma, Greef, Mulaudzi & Wright, 2010). Thus the researcher chose the qualitative research approach to explore nurses' experiences of the assessment and management of patients at risk of absconding. The researcher believes that this research approach provides a true reflection of how the risk of absconding is assessed and managed in an acute psychiatric ward. According to (Hennink, Hutter & Bailey ,2011, p. 82), qualitative research is "an approach that allows the researcher to explore participants' experiences in their natural settings". This approach was found to be beneficial because it would help the researcher to explore and understand the perspective of participants on the meaning they give to phenomena (Green & Thorogood, 2014).

Qualitative research is usually conducted where a need exists to understand the context or settings in which participants in a study mitigate a problem or issue (Creswell, 2007, p. 40).

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In qualitative studies the researcher collects primarily qualitative data that are narrative descriptions (Polit & Beck, 2008, p. 60). The qualitative research method therefore focuses on understanding people and how they define their own world rather than describing or quantifying the events that are happening to them, which makes it different from quantitative research (Polit & Beck, 2008, p. 60).

3.2.1 Research design

Qualitative exploratory and descriptive research designs help to investigate the full nature of a phenomenon, the manner in which it manifests and other related factors (Polit & Beck, 2008). A qualitative exploratory and descriptive research design is especially useful for exploring the full nature of a little understood phenomenon (Polit & Beck, 2008, p. 21). This study employed an exploratory and descriptive design that intended to yield qualitative data in relation to the experiences of professional nurses regarding their assessments, including the guide used and management of patients at risk of absconding in an acute psychiatric ward setting. The explorative process suggests a situation of investigating events and a deeper understanding of their meaning or context and attachments based on how they were experienced (Babbie & Mouton, 2005, p. 14).

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The researcher chose a qualitative exploratory and descriptive research design with the purpose of gaining a deeper insight into the experience of professional nurses by means of interviews, and understanding their role and function in assessing and managing the risk of absconding patients from an acute psychiatric ward.

3.3 Research setting

The study setting is an acute ward at a psychiatric hospital in the Western Cape. It is a district psychiatric hospital situated in the Eastern sub-district of Cape Town Metropole that was

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established in the 1970s. This area is predominately populated by the so-called 'coloured' community, and is beset by mental health problems related to illegal drugs and substance abuse. The psychiatric hospital has a total of 120 psychiatric wards and 1555 beds. Three male and two female acute psychiatric wards provide the MHCUs with services, with 15-20 nursing staff working in each ward (including two professional nurses, two enrolled nursing assistants and one nursing assistant) on both day and night duty; each ward accommodates about 30 MHCUs. For the purpose of this study the acute psychiatric wards were selected because a number of patients abscond while granted leave of absent, from each ward and every month patients attempting to abscond while admitted in an acute psychiatric wards.

3.4 Population

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This study was conducted with professional nurses working at the selected psychiatric hospital in the Western Cape. According to Wellman, Kruger and Mitchell (2005, p. 52), a population is the study object and consists of individuals in the context of the events or conditions to which they are exposed. A population consists of all the individuals or objects with commonly defined characteristics (Polit & Beck, 2008, p. 67). The population was the entire aggregation of cases in which the researcher was interested (Polit & Beck 2008, p. 337). The research problem in this study related to a specific population, namely the professional nurses about whom the researcher wished to make specific conclusions (Wellman et al., 2005. p. 52).

The target population for this study was all professional nurses working in the male and female acute psychiatric wards. Although the total number of nurses working in this particular psychiatric hospital was 443, this study focused only on professional nurses working in the three male and two female acute psychiatric wards. Each ward accommodates 30-40 MHCUs, with nursing staff working both day and night duty. There were 18 professional nurses working in the five acute psychiatric words on both night and day shifts.

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3.4.1 Sampling and sample size

Sampling defines the process of selecting a group of people, events, behavior, or other elements to include in a study (Burns & Grove, 2005, p. 40). Sampling in qualitative research starts with identifying the specific group of individuals in order to gain an in-depth understanding of the topic under study. This means that the inquirer selects individuals and sites for study because they can purposefully inform an understanding of the research problem and central phenomenon in a study (Creswell, 2007, p. 125). Furthermore, purposive sampling is based on the belief that the researcher's knowledge about the population can be used to purposively select sample members (Polit & Beck, 2008, p. 343). Researchers might decide purposively to select subjects who are judged to be typical of the population or particularly knowledgeable about the issues under study.

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In other words, the researcher uses purposive sampling as a way of selecting the units of study, using inclusion and exclusion criteria. The inclusion criteria for this study were professional nurses who must have at least six months of working experience in an acute psychiatric ward. The exclusion criterion was being employed by an agency, and such professional nurses were not included in the study. Sampling is choosing subjects who are judged to be typical of the population in question and are particularly knowledgeable about and experienced in the issues under study (Mateo & Kirchhoff, 2009, p. 78). According to the South African Nursing Council's scope of practice, professional nurses are responsible for the assessment and management of patients at risk of absconding in acute psychiatric wards. Thus sampling strategies included only professional nurses and no other categories of nurses.

A sample is a subset of the population that is selected for a particular study and the members of a sample are the subjects. A sample comprises elements of the population considered for actual inclusion in the study, or it can be viewed as a subset drawn from a population in which

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there is interest according to specific criteria (Strydom, 2005, p. 194). Therefore, a sample size of 10 professional nurses who were purposively selected according to their experience out of the 18 professional nurses participated in the study. Participant selection was continued until data saturation was achieved at participant eight and semi structured interviews continued till participant 10 where no new information being expressed. The researcher was assisted by unit managers in selecting the participants for the interviews. Those professional nurses were working twelve hours shift during day duty and the night shift professional nurses were also working the same hours during night duty for each ward.

3.5 Data collection methods

3.5.1 Semi- structured interviews

The researcher developed interview guide questions based on the objectives of the study. The interview guide questions were designed to flow from a more general question (to be asked first) to more specific questions. The interview guide consisted of open-ended questions which were followed by probing questions in areas where further clarity was needed. The following are examples of interview guide questions developed to answer the research objectives: 'Please explain your experiences of how the risk of absconding is assessed at your acute psychiatric ward?', 'Could you explain your experiences of how you manage patients with risk of absconding from your acute psychiatric ward?', and 'Could you explain your experience of the use of increased observation measures in the management of patients at risk of absconding in your acute psychiatric ward?'. In this study semi-structured one-on-one interviews were used because the researcher's focus was on exploration of nurses' experiences, and this allowed the researcher to expand beyond the format of questions through probing.

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3.5.2 Pilot study

A pilot study was carried out with three professional nurses who were not part of the actual study, but have similar working experience in the same environment. The purpose was to check the relevance and clarity of the interview guide questions and to determine the length of time that each interview will take. This helped to avoid possible errors in data collection such as unclear wording and inadequate time, as well as ensuring that the variables defined by the operational definitions were actually observable.

3.5.3 Information gathering

Data collection commenced on 1 October 2016 and was completed on the 31 October 2016.

An interview schedule was used (Appendix: A) as a guide for the progress of the interviews. Interviews were held in the wards where participants were working at the time of data collection (male and female acute psychiatric units).

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Permission to conduct the study was obtained from the Research Ethics Committee of the University of the Western Cape (Appendix F) and from the Research Ethics Committee of the psychiatric hospital concerned (Appendix E). Thereafter the researcher approached the operational managers of the respective admission units to seek permission to access participants to take part in the study. The participants were approached individually by the researcher after obtaining permission from the ward manager. A meeting was set up with each of the participants where the nature and aim of the study were explained. Each participant was given an information sheet (Appendix C), and those who agreed to take part were asked to sign a consent form (Appendix B).

All of the necessary materials and equipment, such as consent forms, writing pad and pen, audio-recorder and interview room were arranged prior to the interview. Before the interview

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began the researcher explained to the participant about the aim of the study and all ethical principles, so that the participants clearly understood and could decide to participate. Then the researcher asked the participants to sign the consent form stating that they understood the implications of participating in the study and agreed to be part of it. The researcher obtained informed consent from each participant before the interview started; this was also part of assuring the participants of the confidentiality of the information discussed in the interview.

During the interview the researcher started by asking general questions, gradually moving on to more specific questions. For instance, after the general question 'Please explain your experiences of how the assessment of absconding patients is conducted at your acute psychiatric ward', specific questions followed one by one to explore more information about assessment, such as how the risk factors of an absconding patient are assessed. With regard to the management of absconding patients, the researcher posed a question such as 'Could you please explain your experiences of how the risk of patients absconding is managed in your ward?' More probing questions were used during the interview; however, this didn't limit the responses of the participants, as context-driven information may evolve. Field notes were taken during the interviews.

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With permission from the participants the interviews were audio-taped and information of sufficient depth was collected until data saturation was reached (when no new or different information was being reported). The duration of the interviews was about 30 to 40 minutes each and data saturation was reached at participant eight. According to Streubert-Speziale and Carpenter (2007, p. 95) data saturation occurs when there are no new emerging themes or essences from participants. In this study the data saturation was reached at eight interviews, and two more interviews were conducted to establish that no further new essence or no new information were emerged. All interviews were recorded by the audio-recording device and

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were transcribed verbatim. The interview was conducted at a place agreed upon by the researcher and study participants. During interviews none of the participants required counselling after recounting their experiences.

3.6 Data analysis

The data collected in the audio-recordings taken during the interviews were transcribed verbatim, after which the researcher reviewed the data, made notes and began to sort it into categories. This helped the researcher to move the analysis from a wide reading of the data towards discovering patterns and developing themes. The qualitative data analysis began with identification of key themes and patterns, during which the transcribed data were marked with distinctive identifiers (coding) (Guest, MacQueen & Namey, 2012), condensing the bulk of the data. In this way the researcher organised and managed the data and generated concepts from them. The process of coding emphasises pinpointing, examining and recoding patterns (or themes) within the data (Braun & Clarke, 2006). This is followed by locating and assigning codes and preparing the data for entry into the qualitative data analysis software program. The leading computer-assisted qualitative data analysis software package, ATLAS.ti 7 program used. ATLAS.ti enables one to establish lexical and conceptual relations among words, themes and sub-themes. However, the qualitative data analysis package may not necessarily provide the in-depth analysis required, so the researcher manually revisited the data and themes in order to get to the core issues as presented by the participants.

The narrative data analysis used in the study and interpretation involves the following three stages (Sarantakos, 2005; Barry & Elmes (2005); Leininger, 2006): *Stage 1 - data reduction:* The information obtained from the participants is summarised and coded, the data being categorised according to their similarities in order to integrate, transform and highlight the pertinent data. *Stage 2 - data categorisation:* At this stage information that is assembled around

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certain themes and points is categorised in more specific terms, and the results presented in the form of text and matrices. *Stage 3 - interpretation:* This involves identifying patterns of consistencies and regularities, and making comparisons and discovering trends and explanations in order to make decisions and draw conclusions.

3.7 Trustworthiness

In studies that are qualitative in nature the quality of the data collected remains vitally important, and the quality is assessed by addressing the following credibility, dependability, transferability and confirmability (Burns & Grove, 2006, p. 75).

3.7.1 Credibility

In this research project credibility was achieved by providing faithful and accurate descriptions of the phenomena as reported by participants, through providing an accurate account of the participants' experiences as reported by them. Undertaking the three steps of data analysis also ensured credibility of the findings. Credibility was also achieved through multiple reviewing of audiotapes and field notes by the researcher, and giving the summary of the interview to the participants for member checking so that they could confirm that it was a true reflection of their responses. A pilot study was conducted to determine if the interview guide questions were understandable and appropriate for the intended participants. The researcher attempted to enhance credibility by transcribing and continuously listening to the recordings of the interviews, during which participants were allowed to describe their experiences with regard to the phenomenon studied until data saturation was reached. Furthermore, credibility refers to confidence in the truth of the data and the interpretation thereof (Lincoln & Guba, 2005, p. 290 cited in De Vos, A.S. (2011). In this study the data were also assessed by a coder who independently developed themes and categories after being provided with the research objectives and some of the raw

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text from which the categories were developed. These codes matched those assigned by the researcher.

3.7.2 Dependability

Dependability refers to the provision of evidence on how the study was carried out such that if it were to be repeated with the same or similar participants, in the same or similar context, it will generate the same findings (Brink, 2012). The research process must be logical, well-documented and audited (De Vos, 2011). The researcher kept an audit trail of the research process in order to enhance the dependability of the study. There was peer review of the process of analysis, since the supervisor listened to the audio-recordings and read the transcripts; any errors that were identified were corrected.

3.7.3 Transferability

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Transferability entails the extent to which the results can be transferred to or be applied in other settings (Polit & Beck, 2008). The results obtained from this study may only apply to professional nurses at acute psychiatric wards. Thus it may not be possible to transfer the insight gained from this study research directly to other settings. However, the research information could be useful to professional nurses working at acute psychiatric wards in other health psychiatric hospitals. This is ensured by presentation of a detailed description of the participants, research context and setting, which are sufficiently described to ensure a thick description which can be used in a similar context. It is, however, the reader's decision as to whether or not the findings are transferable to another context (Graneheim & Lundman, 2008).

3.7.4 Confirmability

Confirmability entails proving that the data represent the information provided by the participants, and not the researcher's biases or imagination (Brink, 2012). An audit trail was

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used to determine whether the conclusions, interpretations and recommendations could be traced to the source. The data analysis was reviewed by an independent coder in order to assess the consistency of the coding. After the coder went through the interview transcripts he came up with his own codes and themes, which matched the researcher's code and themes. The audit trail consisted of raw data, viz. the recorded audiotapes and field notes; data reduction and analysis, viz. writing up of field notes, summaries and condensed notes; data reconstruction and synthesis, viz. themes that were developed, findings, conclusions and the final report (Babbie & Mouton, 2005). Quotations from the participants were also used in the written report of the study.

3.8 Research ethics

Ethics considerations relate to research ethics and involve a number of activities. Ethics aims to protect the rights of human subjects whilst ensuring that scientific research takes place (Streubert-Speziale & Carpenter, 2007).

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Ethical approval was obtained from the University of the Western Cape Research Ethics Committee. Permission to conduct the research was granted by the Department of Health of the Western Cape and the Research Ethics Committee of the psychiatric hospital concerned. In this study the researcher respected the rights of and protected the participants by adhering to the ethical considerations outlined below.

Privacy: The researcher gave the participants an opportunity to determine when and where the data should be collected. The researcher also ensured that the information obtained from the participants was not shared with anyone else except the researcher and supervisors involved in the study (Burns & Grove, 2006). The information sheet contained the aim, objectives and the questions to be asked during the interviews. It also outlined risks and benefits involved in the study and the appropriate measures to be taken in the case of traumatised participants.

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The information sheet explicitly explained that participation in the study was voluntary and that the participants could withdraw from the study at any time that they wished to do so. It also explained that withdrawal from the study would not affect the relationship of the participant with his/her employer.

Confidentiality and anonymity: The researcher ensured that the information discussed with the participants was not disclosed to anyone else, except the supervisor of this study. This is supported by the fact that the researcher transcribed the recordings himself. To further ensure confidentiality, tape recordings and transcripts were locked in a cupboard for the duration of the study and will be securely stored for five years before they are destroyed. The informed consent letter (Appendix B) and information sheet (Appendix C) that were provided to each individual participant informed them that in no way were they forced to participate. The participants were also assured of the confidentiality of the information, and that the identifier would be kept anonymous during the dissemination and publication of the results of the study.

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Anonymity: The researcher ensured that all identifiable information was removed from the interview transcripts. Wherever possible data should be collected, stored or handled in anonymous form. Where linkage between data sets is required (e.g. in longitudinal studies) record numbers should be used as far as possible, with special measures to protect the key that would link a number to personal identifiers (Hennink, et al., 2011).

Autonomy: The research should be guided by the principle of respect for people that is the recognition of the participant's rights, including the right to be informed about the study, beneficence and justice. The participants were clearly informed that they had the right to withdraw from participating in the study at any time, without any penalty being imposed (Burns & Grove, 2006). The researcher ensured that participants took part in this study voluntarily (Brink, 2012).

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Justice: Participants participated in this study because they met the study criteria for inclusion. The principle of justice refers to equal share and fairness, and the distinctive features of this principle are avoiding exploitation and abuse of participants (Creswell, 2007). In qualitative research studies the vulnerability of the participants and their contribution to a study is recognised (Polit & Beck, 2008).

Risk/benefit: In this study there were some potential risks for participants, although these were minimal. Since the researcher wanted to explore personal experiences, some participants might have some negative experiences that might affect them emotionally during semi-structured interviews. A counsellor and psychologist were made available should any of the participants have required counselling after an interview. The researcher avoided any harm to participants. They were referred to a psychologist stationed at the psychiatric hospital, this being prearranged by the researcher. (Polit & Beck, 2008). However, none of the participants needed referral and no reward was offered to the participants for participating in this study.

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3.9 Conclusion

In this chapter the researcher provided a detailed description of the methodology that was employed in the study, including clear steps concerning the means by which data were collected and analysed. The next chapter focuses on the presentation of the findings.

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CHAPTER FOUR

RESULTS

4.1 Introduction

This chapter presents a detailed description of the findings from this qualitative study, the results that emerged from the data analysis having been categorised into themes and subthemes.

Firstly, a description of the demographic profile of the participants is presented, followed by a brief description of how the coding was generated from the units of analysis. A review of the various themes and subthemes that emerged from the analysis is presented. The objectives of the study were used as a reference during analysis of the data. The aim of the study was to explore and describe the nurses' experiences of risk assessment of patients at risk of absconding from an acute psychiatric ward, the use of containment measures and increased observations measures for the management of patients at risk of absconding.

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4.2 Demographic profile of participants

A total of 10 male and female professional nurses participated in the semi-structured interviews. All (n=10) of the participants were between the ages of 20 and 55 years. Only two participants were between the ages of 20 and 30 years. Most of the participants were Black African or Coloured. All participants were able to speak English, but their mother tongue was Afrikaans, IsiXhosa or IsiZulu. Table 1 shows the demographic characteristics of participants in the study

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Table 1: Demographic characteristics of participants

Identifier code	Age group (years)	Gender	Race	Nursing category	Years of experience in an acute psychiatric ward
P0 1	40-45	Male	African/Black	Professional Nurse	16
P02	30-45	Female	Coloured	Professional Nurse	6
P03	40-55	Female	Coloured	Professional Nurse	15
P04	30-45	Male	Coloured	Professional Nurse	13
P05	30-35	Female	Coloured	Professional Nurse	6
P06	30-45	Male	Coloured	Professional Nurse	11
P07	20-30	Male	African/Black	Professional Nurse	3
P08	20-30	Female	African/Black	Professional Nurse	3
P09	30-40	Male	African/Black	Professional Nurse	10
P10	40-50	Male	African/Black	Professional Nurse	7

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4.3 Presentation of themes and subthemes

After familiarisation with the data by reading the transcript three times, initial codes were generated with a focus on coding interesting features of the data in a systematic way. Three main themes emerged: risk assessment; risk management; and increased observations. The sub-themes were: assessment of high-risk patients; risk factors/characteristics of absconding patients; risk assessment form; assessment for patients granted leave of absence; nursing care

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plan; observation policy; and increased visibility of nursing staff. Although each of these is discussed separately, it is important to note that the themes are interrelated to form the entirety of exploration and description of nurses' experiences of the assessment and management of patients at risk of absconding.

Table 2 provides a summary of the themes and sub-themes that emerged from the data analysis.

Table 2: Themes and sub-themes that emerged from the data

No.	Theme	Sub-themes
I	Risk assessment of patient likelihood of absconding	• Assessment of patient's high risk of absconding. • Risk factors/characteristics of absconding patients • Assessment form of an absconding patient. • Assessment for patients granted leave of absence. • Nursing care plan
II	Risk management	• Prevention and therapeutic relationships • Containment • Minimise risk of absconding.
III	Increased observations	• Observation policy

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		• Increase visibility of nursing staff

4.4 Theme 1: Risk assessment of patient likelihood of absconding

Participants mostly reported during the semi-structured interviews that patients admitted in an acute psychiatric ward were seen by doctors and professional nurses during assessment; nurses check if a patient is at high risk for absconding or has a potential risk of absconding by looking at the history of the patient from previous institutions, the specific diagnosis of a particular individual, the relative age group (some have more of a tendency in terms of absconding), and the presenting symptoms of the patient currently, because some may be using substances. One of the challenges in terms of being able to assess patients is that professional nurses need to be skilled enough in order to determine some of the risk factors that can predispose patients to absconding. For example, Participant 8 commented as follows:

> *"When admitting a patient, we do a risk assessment, we need a short history of a patient from a previous institution or an abscond risk, the aggression level of the patient, the insight in terms of illness and in terms of hospitalisation, because if there is no insight that we need to admit a patient be treated in an acute unit".*

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Five subthemes emerged under the main theme of risk assessment: assessment of high-risk patients, risk factors/characteristics of absconding patients, risk assessment form, assessment of patients granted leave of absence, and nursing care plan. These are described below, supported by verbatim extracts from interview transcripts.

4.4.1 Sub-theme 1: Assessment of patients at high risk of absconding

Participants in this psychiatric hospital reported that every patient arriving at an acute psychiatric ward, which is an acute admission ward, should be assessed for potential risk of

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absconding, because these patients have a potential to harm themselves and others. However, while other participants in acute wards agreed that assessment of a patient's risk should be made as soon as possible once the patient arrived on the unit, Participant 4 described his experience of assessing high risk of absconding as follows:

> *"... when we admit a patient from another hospital we do risk assessment in terms of potential risk of abscond, so firstly we look at the history of patient, did he/she abscond from previous institution, patients because they are at high risk of absconding* [it is] *only one of the questions that we are looking at, there is no standard form in terms of assessing absconding".*

Participant 2 was currently in charge of an acute psychiatric ward and described the assessment of high risk of absconding as follows:

> *"Assessment on admission, we do a mental state examination of a patient, but there is not a specific tool that has been used where I can say that we tick off. But we mentioned at the nursing care plan, we do an initial entry of a patient, it gets documented".*

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Participant 5 reported that they do assess the previous history of the patient and use standard tools to determine the risk of absconding:

> *"My experiences in terms of how we assess the risk of absconding when patients are admitted, what we do is, we have a standardised guide drawn in the ward, so we already know in terms of high-risk patients, those that are having history of absconding, depending on what the patient is presenting when you read the history and the information you get will highlight the risk. Patients present with what are the reasons for admission and patients isolating themselves; we begin to do risk assessment".*

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4.4.2 Sub-theme 2: Risk factors/characteristics of absconding patients

Participants currently working in an acute psychiatric ward illustrated their experience of assessing the risk factors or characteristics of patients at risk of absconding. They expressed that patients had a poor insight into understanding their illness and why they were admitted to the psychiatric hospital, and then tended to act out and demand to go home when there were no negotiations in terms of patients being mentally ill. Participant 6 described this as follows:

> *"It's very important that you need to understand the history of patient so that you know if patient is prone to absconding. What does the patient present with, social circumstances, what is the relationship with the family, the extent of their condition, is the patient having auditory hallucinations, hearing voices telling him /her to abscond ..."*

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Participants expressed their experience of working in acute psychiatric wards for the past years in terms of assessing risk factors or characteristics of an absconding patient. Being able to assess was one of their critical challenges. One had to be skilled enough in order to be able to determine some of the risk factors for example change of patient behavior, risk of aggression, previous history of abscondment that can predispose patients to absconding. Participant 7 pointed out as follows:

> *".... one of the things we are looking at is the history of the patient in the psychiatric services with absconds, second one would be looking at specific diagnosis of a particular individual, three the relative age groups that are also having a tendency in terms of absconding. The presenting symptoms of this patient - for instance those patients using substances. However, now they have developed a tool in assessing these risk factors of absconding and also assessing injuries."*

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Participant 2 stated the following risk factors such as patient behaviors:

"Obviously with the history of patient absconded it is likely to occur again, secondly we look at agitation, aggression behaviours, sometimes we find out patients are not following the ward routine, patient is not taking medication or not swallowing, actually is becoming more psychotic…"

4.4.3 Sub-theme 3: Assessment form of an absconding patient

Participants stated that a standardised risk assessment form was an important documentation for analysis of risk, although there was concern at focusing on the standardised guide instead of conducting a complete assessment form. Participant 8 mentioned as follows:

"Basically what we do when admitting a patient, we do a risk assessment form. On that risk assessment form there are questionnaires that we need to consider where we assessing the risk for absconding of a patient"

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Similarly, Participant 7 pointed out:

"We've got a standardised risk assessment form that we developed here for adolescents and you tick it off, you will see depending on the score if a patient is a low risk, moderate risk or very [great] *risk of absconding. The form is threefold, so it has responses: harm to other, and harm to self. So it will give you individual scores for each one of that category, so we go according to that"*

Said Participant 10, who is in charge of an acute psychiatric ward:

"Basically we assess either by observation on patient behaviour and also with patient's interview, we assess risk in that manner"

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4.4.4 Sub-theme 4: Assessment of patients granted leave of absence

Participants illustrated their experience of assessing patients who have been granted weekend leave, taking into consideration that this it is not only determined by a decision made by a multidisciplinary team based on the current behaviour of a patient in this setting, whether there is any potential risk of suicide, homicide, or potential risk of violence and risk assessment of the patient. In some cases, when the family requests a patient for weekend leave, this is into consideration. Participant 6 pointed out as follows:

> *"…we may use weekend leave as therapeutic intervention sending patient out ensuring about how he is going to cope with the behaviour with circumstances outside, although we don't have formal structure…"*

Participant 8 described their assessment experience as follows:

> *"… assessing patients that are going on weekend leave, for instance a patient is discussed in a ward rounds, the multidisciplinary team do agree to clinical objectives, is able to go on weekend leave. Understanding what we look at, patient must be manageable in the ward, a patient must be apsychotic, mental state if patient can cope to stay with a family…"*

Participant 7 commented as follows:

> *"… as part of the rehabilitation programme and in terms of the decision making by multidisciplinary team to be assessed by doctor, nurses had to give input, psychologist has to give an input how the patient is going to cope at home …"*

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4.4.5 Sub-theme 5: Nursing care plan

Participant 2 who works in an acute psychiatric ward mentioned their experience on how they assess risk of absconding during the patients' nursing care plan:

> "*We classify all patients as high absconding risk. What we normally do with them is to ensure and see that we assess inpatients by doing a Mini-Mental State Examination, we also check how many patients we got, and observe them on regular basis in the ward. Nursing staff check in the notes if any risk of absconding on prior occasions, we do a regular head count and we record on the nursing process as an interim"*

Participant 4 stated: *"... basically we have a specific risk assessment that we use on the findings of the overall assessment, we will then merge the patients accordingly."*

The day-to-day documentation of the characteristics of the patient and unpredictability were mentioned by Participant 1:

> *"We do a day-to-day report on nursing process that we write about, the patient for instance is demanding to go home, patient is unpredictable, that type of thing that will indicate that patient will try an abscond and especially if they are withdrawn ..."*

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4.5 Theme 2: Risk management

Participants suggested the need for development of improved strategies that include aspects such as previous circumstances and elements and outcomes of absconding incidents. Debriefing of patients should also occur, as well as prevention and therapeutic relationships, containment measures with locking of doors as a priority and the use of chemical and physical restraints, noting that this reduces opportunistic absconds.

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Participants mentioned provision of therapeutic relationships, for example listening to the patient and attending to personal needs or addressing issues as a way to calm the patient, as well as family involvement (asking whether siblings are coping with a patient at home, his or her behaviour, and if the patient adheres to the treatment). Participant 8 stated:

> *"The patients who are abscond risk in our acute ward, if we saw while we doing assessment and we found that the patient is at risk of absconding, we will allocate a specific nurse to that patient on one-on-one basis. He/she, a nurse on duty to observe wherever the patient is, will give nursing care to a patient and in terms of speaking to a patient address the issues, making them understand the need to be in hospital in order for patient to get well."*

Three sub-themes emerged from this main theme: prevention and therapeutic relationships, containment measures and minimise risk of absconding in an environment. These are described below, with direct quotations extracted from the data on experience in management of patients at risk of absconding.

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4.5.1 Sub-theme 1: Prevention and therapeutic relationships

Participants in charge of acute psychiatric wards expressed that patients needed to receive more attention and greater access to nursing staff in the therapeutic relationship, and required closer attention to their personal needs. It is important to support and help patients in order to calm them if they are having feelings of restlessness or inappropriate behaviours or being violent. Participant 5 reported as follows:

> "*… in a therapeutic ward at the moment we don't believe in firstly giving patient sedation, we need to understand the patient and we need to observe the patient; for instance, if he/she is restless, pacing up and down. We speak to the patient, try*

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therapeutic measures to calm the patient. We address the issues of the patient and understand them, give them space. Maybe the patient is emotionally distressed. If we see those measures are not helping, then we can as a last resort sedate a patient if there is a need to do that ..."

Participants mentioned different therapeutic risk management measures used such as monitoring patient's movements, in-service training for the staff removing patients from a stimulating environment in an acute ward as a way of preventing absconding. The following extracts illustrate this:

Participant 6**:** *"In an admission ward, we have more movements because inpatients are going to occupational therapy, psychology groups and physiotherapy groups, so there is a need for us to be careful in terms of how are we going to manage these movements, because patients are walking"*

Participant 3: *We are making sure that our nursing staff getting an in-service training to minimise the risk, we cannot guarantee that absconding will disappear but we can from our part minimise the risk…"*

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Said Participant 5, is in charge of an acute psychiatric ward mentioned that some patients presenting with symptoms of irritable, restless and others withdrawn planning ways of absconding:

"If there is something agitating a patient you try to take [them] *out that environment if that is possible and talk to the patient out, if there is a lot of irritability or aggression and a nurse managing a patient needs to be calm in his/her approach, not showing any anxiety, to be able to reflect to a patient and body language should be calm and non-threatening"*

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Participants mentioned that strategies could be developed to offer therapy for patients who are at risk and about to leave the treatment unit. Psychiatric hospitals should take care not to respond to threats in this context with negative responses, punitive actions, or punishment. Instead, these threats should be viewed as an opportunity to discuss with the patient his or her reasons for leaving care, possible solutions to help the patient remain safely in care, and potential outcomes that the patient may encounter upon leaving, for example, risk of harm to self and others. Participant 4 pointed out as follows:

"It is not really enough support in terms of preventing patient from absconding right with regard what we use, basically as explained, nursing staff and security need to be more vigilant, for instance in some cases patient going to physiotherapy where in some cases it is working and others it doesn't work. We cannot predict when the patient is going to abscond. We make sure that we have all measures in place in prevent the patient from absconding. On the other hand, unfortunately the Western Cape is one of the places where most inpatients use substances, including cannabis and alcohol abuse"

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As Participant 5 stated:

> *"It started with the nursing staff because you look at 40 inpatients and having seven nursing staff in the unit, how can one actually have one-on-one observation with inpatients? We have the ability to prevent absconding and we need to work on staff ratio with patient ratio. So if look at the area, it's a fence that is electrical that can be easily jumped, the external fence needs to be higher to prevent inpatients from absconding easily and injury"*

Participant 2 shared as follows:

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"If we see that a patient is a high risk for abscond and we needed support, we ensure by getting support personnel available as well and just be clear that he/she should be non-threatening in an approach to a patient …"

4.5.2 Sub-theme 2: Containment by locking ward doors

The most effective containment practice demonstrated by participants was chemical restraints, the use of physical restraint as last resort, seclusion rooms and the locking of ward doors. For this reason, participants believed that ward doors should be locked at all times. Participants mentioned that some patients actually verbalise that they want to go home; they will jump at any point of time, and start displaying agitation or restlessness where they will start being aggressive. The point here is not only the absconding in itself, but also the risk for patients, as the patients being injured means a much more complicated risk.

Participant 7 described the use of chemical restraint as a containment measure as follows:

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"*… Once we start seeing that patient we will use chemical restraint which means giving something for sedation, lorazepam 4mg po/imi that is available as prescribed. We indicate the overseeing doctor, explain to the doctor that patient so and so would need it. If patient become violent and aggressive, in that moment we often use mechanical restraint to send the patient to a ward where there is a proper seclusion facility and seclusion procedure will be followed as prescribed by doctor."*

Participant 1, working in an acute psychiatric ward verbalised the use of containment measures as follows: "*Chemical restraint is the medication right, so inpatients might be on anti-psychotic or mood stabiliser and lorazepam in any psych ward … Now with kids* [patients] *if they are on lorazepam it has a paradoxical effect which means instead of sedating the kids* [adolescents] *it makes them hyper, it makes them more active, more impulsive, and when impulse control is*

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gone, we motivate to the doctor to prescribe regular Benzo not lorazepam, it will be either clonazepam or diazepam per os, so they will get that regularly eight- hourly; we will keep them contained with that. We can use lorazepam in between to top up if we want to keep them calm on that level; that is a chemical measure we use and also give antipsychotics ..."

Participants in an acute psychiatric ward mentioned that physical restraint is recommended only as a method of last resort, patients being placed in a seclusion room as prescribed by a doctor for the management of violent or challenging behaviour because of concerns for patient safety. The patient is observed while being kept under seclusion. Participant 5 in charge of an acute psychiatric unit described use of physical restraint in an acute psychiatric ward as follows:

> *"Physical restraint, if patient is at high risk for abscond we will keep them in the ward, all our doors are locked so they don't have a freedom of movement in our ward; it is an acute admission ward. If there is an inpatient that is trying to break windows, or being violent (because they try to do that), we have the right to place a patient in seclusion, but the doctor must come and prescribe seclusion, so that is another measure we will try and contain them."*

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Participant 3 described seclusion as a containment measure as follows:

> *"Sometimes we use physical restraint in the ward. Seclusion must be done when patient is locked up for two hours as prescribed by the doctor. After two hours we do another risk assessment as to how the patient is now, is he/she still a risk of abscond, injury to himself and others, and see if the doctor can prescribe seclusion again. We try and contain on three levels, environmental, chemical and physical restraint; that is the framework we are working of containment."*

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Locking the door of the ward is one of the containment measures used by nurses to manage absconding. The following extract from Participant 6 illustrates this:

> *"The most important thing in acute psychiatric wards is locking of the doors, all the doors should be locked at all times. We must see if the nursing staff all have the keys to have access to doors, access to burglar exit door, and make sure it is locked and the securities open and close for people not from the unit. We are using a central locking system which is operating only in the office and now we are in a process of using a tagging system. Only the nursing staff will have a tag to be able to open the doors…"*

Participant 5 reported as follows:

> *"We tried to emphasize to nursing staff that doors should be locked at all times, keys not to be kept at reach of patients in case of keys hanging on security guard's pockets. For patients who are used to, who are comfortable with the environment, it's easy for them to observe what key fits in…"*

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4.5.3 Sub-theme 3: Minimise risk of absconding

Participants mentioned how the facility's physical layout can create opportunities for patients to find ways of absconding. The nursing staff including the security staff should become aware of the escape routes. Said Participant 7:

> "*We have tried to improve in minimising risk because of the conditional incidences; for instance, having a facility [where] the structure itself does not have maximum protection of MHCUs; somewhere still has an escape route, which is beyond our capacity, as I said. To ensure the staff aware and educate more of our junior nursing staff in terms of those risks and also teaching of the security staff about preventing in such situations…"*

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Participant 8 reported as follows:

> *"If a patient feels unsafe in an environment, patient hearing voices, some of these voices are command hallucinations telling a patient to leave the hospital, and some of these patients respond to the commands. We do a Mental State Evaluation ..."*

4.6 Theme 3: Increased observations

Participants stated during the interviews that increased observations measures were usually applied in an acute psychiatric ward, patients being observed two-hourly according to hospital policy, with the use of cameras and CCTV monitors during ward rounds and when a patient's perceived risk of absconding and harm (either to themselves or others) is recognised. In this mental health setting this type of observation is characterised by a greater degree of focus and the closeness of it to the patient.

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4.6.1 Sub-theme 1: Observation policy

Participants in this particular psychiatric hospital stated that they had an observation policy in their unit, with a standard operation guide for the nursing and observation of patients. Participant 3 stated as follows:

> "*... we ensure that nursing staff members sitting with patients and securities observe at all times and also the wards have cameras, CCTV monitor in the office area, and we don't sit the whole time, we monitor more than three times. The most important thing is the visibility of the nursing staff between the patients ...*"

Participant 2, who works in a male acute admission ward: *"... we continuously observe patients, so what we do we use monitors when patients are sleeping, securities do rounds and in terms of handover and the hospital policy says that patients should be monitored two-hourly..."*

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Participant 8 pointed out as follows:

> "*… we increase observation especially with adolescents, they are very unpredictable. We do put our increased observations, one-on-one nursing, we allocate a nurse specifically to look after an inpatient so they will look from the morning till evening and handover to next shift. We do have the CCTV monitors except in the bathrooms for patients' privacy. Nurses are always vigilant with the patients, so if they need to go for any special investigation we will arrange for extra security officer and one of our nurses will escort the patient…"*

4.6.2 Sub-theme 2: Increased visibility of nursing staff

Participants verbalised the need for a policy for assessment and care management of patients who were at risk of absconding in an acute care setting by ensuring a patient has an escort for all tests outside of the main psychiatric setting, and where possible re-orientates a patient on their return. Where possible they should also accompany a patient whilst they walk, this will reassure the patient, making them feel more at home in the environment and less likely to leave. If a patient can be accompanied for a longer walk so that they can leave the ward or department for a short time, this can be beneficial.

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Participant 3 who works in a female acute psychiatric ward stated the importance of being vigilant:

> *"When a patient ready for discharge and we identify that a patient is an abscond risk, we send the patient back to more containing unit for close supervision, where there is more visibility of nursing staff and securities"*

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Participant 4, from a male acute psychiatric ward, mentioned as follows:

"During ward rounds on Wednesdays we need more nursing staff from other acute wards to balance patient and staff ratio for close observations because some of these patients get agitated, restless, they just want to be discharged and they want to go home."

Participant 7 stated:

> *"... it is normally more about identifying high-risk patient previously, why is the patient pacing up and down, and now we start monitoring more closely and also giving them prn medication ..."*

4.7 Conclusion

Chapter Four presented the findings of the study exploring of nurses' experiences of assessment and management of patients at risk of absconding from an acute psychiatric ward. The findings revealed the different experiences of nurses while assessing and managing patients at risk of absconding. The findings were presented in terms of the three themes that emerged during the interviews. Nurses reported that every day brought new challenges in the management of MHCUs in an acute unit, and that it was not an easy task, especially under circumstances that include a shortage of staff. The next chapter focuses on discussion of the findings.

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CHAPTER FIVE

DISCUSSION OF THE FINDINGS

5.1 Introduction

This chapter presents the discussion of the results of this study by comparing them with the available evidence in the relevant literature. The objectives of this study were threefold, to explore and describe: nurses' experiences of the assessment of patient at risk of absconding from an acute psychiatric ward; use of containment measures for management of patients at risk of absconding from an acute psychiatric ward; and the use of increased observation measures for management of patients at risk of absconding. The findings of this study are discussed according to these objectives.

5.2 Risk assessment

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The findings of the study identified that the risk assessment process involved the use of multiple sources of information to obtain an overall picture of risk. In this way assessment became a consideration of the interrelationship of multiple potential risks, as was understood from participants' viewpoints. The results of this study reveal that risk assessment therefore involved using numerous sources of information for nursing care plan (e.g. previous history of absconding, psychiatric diagnosis, presenting symptoms, and gender), the use of a risk assessment form and making a judgement about what is related to risk.

The findings of this study are in contrast to those of a study conducted by Muir-Cochrane and Wand (2009), which identified that nurses conceptualised the underlying purpose of risk assessment as ensuring safety, a perspective which accords well with dominant conceptions of risk assessment. The researcher suggests, with regard to assessment of risk, that professional nurses should undergo training programmes that will assist and equip them with adequate skills

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in assessment and modern management strategies for patients at risk of absconding. The researcher's evidence reveals that national guidelines or recommendations are required to inform the development of evidence-based policies and strategies for risk assessment and safety planning at organisational and clinical practice levels.

Important sources of information were considered by the participants, one of these was through family involvement, for example, the behaviour of a patient and cooperativeness while staying with siblings, and if the family was able to cope with the patient's behaviour. Caregivers were identified as a rich source of collateral information and care planning, particularly when they have cared for the patient and have knowledge of their history; for example, patients being compliant with their medication, personal hygiene and behaviour changes. These findings also related to those of Mosel et al. (2010) that illustrate the importance of involving patients directly and giving them responsibility in their management, family and caregiver involvement, as well as additional factors such as open communication, and acknowledgement of the patient's rights, in getting to know more about patient behaviour in assessing the risk of absconding. Furthermore, the study identified assessment of the history of the patient, particularly the background of the admission, including events prior to hospital presentation, as important.

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The findings of the study reveal that the current methods of risk assessment are inadequate, highlighting the need for a standardised guide to be used in combination with a risk assessment form. Similarly, Woods (2012) highlighted that methods of risk assessment need structured tools to be used in combination with clinical judgement. Furthermore, these findings are comparable with those of Bowers, Alexander and Gaskell (2007) that reported from literature on risk assessment that reliance on clinical judgement alone is ineffective.

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Nurses seemed unaware of the need for on-going structured risk assessment of absconding, with one nurse saying "every case is different", when it is known that absconding-reducing interventions have proven to be effective.

The study reveals that during admission of involuntary new MHCUs in an acute psychiatric ward in this particular psychiatric hospital, some patients did not have insight into why they had been admitted. As a result, they did not adhere to the treatment and care, and wanted to leave the hospital setting. Hence, during admission nurses compile a risk factor assessment for absconding patients – especially for patients at risk of absconding and with previous history of absconding.

The findings of this study are supported by those of Gerace et al. (2013) which state that risk assessment processes involve the consideration of actual and perceived risk to patients and others, which includes consideration of factors such as current or past behaviour and mental state. The findings of the study illustrated that some of these patients will be quiet at one minute and the next minute you will see the changes in their behaviour. The study also identified that some patients are moodier and withdrawn, and in such cases, they may be planning ways of absconding. Such risk factors need to be considered. The findings in this study are comparable with those of Grotto et al. (2014), who demonstrated actuarial methods of risk assessment, or 'second generation' approaches, which involve the use of a formal, reasoned approach to assess empirically measured risk factors through the use of validated instruments or tools.

The findings in this study reveal criteria for assessing patients that are going on weekend leave; for instance, the patient is presented in a ward round, participants agreed on clinical objectives as to whether the patient is suitable to go on weekend leave, and the multidisciplinary team looks at the safety of the patient. Firstly, patients must be manageable in the ward; the patient might still be psychotic because some of them had presented with such symptoms. The findings

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of this study are supported by those of Carr et al. (2008), which state that closer evaluation is necessary before a patient is granted leave, and also suggested that on a personal level nurses should consider the meaning of an admission for a patient and the significant impact on their daily life. In a similar study Muir-Cochrane et al. (2012) also identified that overall amounts and frequency of leave for each individual patient are agreed in consultation with the multidisciplinary team and modified in the light of on-going risk assessment.

Moreover, leave of absence would normally be granted when patient is cooperative in a therapeutic environment and being safely managed by the patient. The study identified a critical challenge as being how to assess the characteristics of patients likely to abscond; one has to be skilled enough in order to be able to determine some of the risk factors that can predispose patients to absconding. This finding is supported by McGuinness, Dowling and Trimble (2013), who suggested that staff ought to be experienced and skilled to deal with mentally ill patients, with activities in the ward being interesting and perceived as useful, and programmes designed to meet different levels of patient functioning.

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In this study it was identified that weekend leave is granted during discussion with the multidisciplinary team or ward rounds about a patient, based on the patient behaviour in the ward, such as if there were no incidents or signs of agitation and a patient is able to stay with family by assessing mental state and their behavior in the ward. The decision-making process during risk assessment, patients are to be assessed by a psychiatrist doctor, with the psychiatric nurse to give input to the psychiatrist as to whether the patient will be able to cope at home. This study identified that even if patients do not have family or friends close by they may attempt to abscond, which can result in them being homeless and might cause deterioration in their mental state.

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Furthermore, when patients being able to abscond from a psychiatric institution results in family not trusting in mental institutions. Regarding the implications of absconding, the findings of this study are comparable with the findings of the study conducted found that an absconding event creates trust issues, with families losing confidence in both psychiatric services and the unit when patients find ways to abscond (Walsh, Rooney, Sloan, McCauley, Mulvaney, O'Callaghan & Larkin, 2010). The findings of studies conducted by Gilburt et al. (2008), Meehan et al. (2010); and Muir-Cochrane et al. (2012) suggest that specific to absconding, focusing on a good partnership with patients remains important, as it is likely to lead to nurses detecting markers of absconding such as patient perceptions of safety, fear, distressing symptoms, boredom, and concerns relating to home responsibilities. However, the findings of the study conducted by Stickley and Felton (2013) indicate that any approach to risk needs to be organisationally authorised, with responsibility held by the service rather than the practitioner – therefore policies, guidelines and management support are also required to create an environment that is amenable to manage the risk of absconding. The researcher argues that there is a need for training support for all nursing staff about basic assessments and management of risk emergencies.

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5.3 Risk management

As defined by the South African Mental Health Act 17 of 2002, it is the nurses' obligation as mental health providers to follow a specific procedure to protect MHCUs through a procedure on absconding (Szabo, 2006). Risk management of a patient on their admission, the ward therapeutic environment and treatment have been identified as important to reducing incidents of absconding and other risk behaviours in acute care settings. The study identified the importance of providing emotional support as a way to calm patients as well as family involvement prior to the implementation of containment measures. The findings of the study

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reveal that nurses don't believe that giving patients' sedation is a method of risk management. However, their emphasis on observation of patient behaviours such as restlessness, and creation of therapeutic relationships with a patient using therapeutic measures to calm them, address the issues of the patient and giving the patient space may be relevant steps in risk management of the absconding patient.

In line with the current findings, Bowers (2009) indicate that patients require closer attention to their personal needs since they view absconding as an effective strategy for meeting those needs- – and therefore feel a greater sense of security when these needs are met. First option measures did not help to calm the patients, and the patients were given sedation medication as prescribed by a doctor. However, some patients given sedation such as lorazepam may become hyperactive, or very impulsive. In such case the nurses needed to motivate to the doctors to prescribe regular psychotic medication. In a similar study Briner and Manser (2013) reported that absconding risk management involves actions to address and minimise the assessed risk; this may include the use of intensive support, time out, sedating medication, as well as containment methods such as seclusion, restraint, and the locking of ward doors or parts of units. This provides a positive reflection on the nurses because they are recognised as supportive of the patients; quite a few patients see it as a positive thing that nursing staff are checking on them to see if they are still there. Locking ward doors was the method used to contain patients, particularly high-risk patients, from absconding.

The findings in this study are comparable with those of Muir-Cochrane et al. (2011) who studied three acute and seven rehabilitation wards; in their study the greatest number of absconding patients occurred from locked acute wards. The findings in this study are similar to those of that conducted by Bowers (2009) which reported that there is a strong association between locked doors and increased violence and aggression on wards; this suggests that

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introducing effective structure and order on the ward alongside other quality improvements may be more effective interventions.

In addition, this study revealed that physical restrain was done when patient was at high risk, for example when the patients do not want the treatment care, very aggressive, agitated, and very psychotic because patients didn't want to accept the new environment setting and nurses used the method as last resort. However, Bowers (2013) argues that physical containment measures are not enough to reduce absconding and may result in trauma, demonstrated that there are precipitating factors that include both environmental factors interacting with organic variables and psychological traits that contribute to absconding as a whole. This notion is reinforced throughout the literature included in this review.

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Professional nurses needed to give motivation to doctors to prescribe two-hourly seclusion according to the hospital policy, later to be assessed as to whether they still presented risk of harm to themselves or others. Happell and Harrow (2010, p. 166) demonstrated that the practice of containment is one of the few options open to staff to manage violent or aggressive and absconding patients; this was reflective of participants' views of containment as their only option for managing absconding risk, even though few patients that abscond were violent. Locking of ward doors was considered very important in acute psychiatric wards; patients have access to doors, burglar doors and exit doors, and these should be locked at all times. All patients should be monitored under close supervision. According to Muir-Cochrane et al. (2011) the most effective containment practice identified by nurses was locking ward doors. Some nurses believed that ward doors should be permanently locked; while they acknowledged that patients could feel 'trapped', they believed that this outweighed the risk of them absconding, given the lack of alternatives. The findings in this study are in contrast with those

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of the study conducted by Ashmore (2008), where it was perceived that locking ward doors results in a higher degree of aggression on the ward and stimulates patients to use more dangerous methods of absconding. In our study the nurses were aware of management strategies and were practising according to hospital policy when they locked doors, stating that it was the way to maintain patient safety if a patient is perceived to be at risk of absconding. This finding is in contrast with the findings of a study conducted by Meehan et al. (2010), where the nurses also reported a belief in containment strategies for managing the risk of absconding, in spite of confusion as to the correctness and usefulness of these strategies. This was complicated by an awareness of ongoing debate in research and policy literature regarding their use, particularly the view that some forms of containment are perceived by both patients and nursing staff as controlling, punishing and at times excessive.

Based on the findings of the study it is argued that specific policy be designed and implemented for returned absconded patients; there is little to suggest that the situation in South Africa will be improved following implementation of Mental Health Care Act.

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5.4 Increased observations

Increased observation was one of the approaches identified for management of the risk of absconding. This was perceived to be a helpful measure for nurses as it allowed them to know where the at-risk patients were at all times. A challenge regarding increased observation in this particular psychiatric hospital was the nursing staff to patient ratio; for instance, four nurses were allocated for 40 patients in an acute ward. There were inadequate nursing staff numbers to effectively increase the observation measures as the best option to manage the risk of absconding.

With regard to reducing absconding Mosel et al. (2010) highlighted the belief that absconding occurs at higher frequencies during nursing handover periods. This study also revealed that

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nurses have difficulty in conducting one-on-one observations and increasing their visibility in acute psychiatric wards because additional nursing staff are needed to observe patients during ward rounds. Some patients become agitated or restless during ward rounds when they see other patients being discharged. The findings of this study are supported by the findings of Nijman et al. (2011), who reported that special observations in psychiatric practice is usually applied when there is a perceived increased risk of harm, either to the patients themselves or others. In mental health settings this type of observation can be distinguished from more general observation by the level of intensity and closeness to the individual being observed.

This study identified during interviews the practice of continuously observing patients and also using monitors when patients are sleeping; the security staff do rounds and in terms of handover and according to hospital observation policy, it was stated that patients should be monitored two-hourly. In this psychiatric hospital the study identified that an observation policy exists in the wards in terms of the nursing guide on observation of patients. The findings of the study differ from those of a study conducted by Kettles & Paterson (2007), which demonstrated reasons for initiating special observation of patients admitted in an acute ward; for example, patients in an intoxicated state may require intensive supervision during the first few days of treatment. These patients may also present with elevated levels of aggression. In the current study those working in male and female acute psychiatric wards mentioned that nursing staff members sat with patients and security staff to observe at all times, and the wards also have cameras with a CCTV monitor in the office area. The findings of this study are in contrast with those of a study conducted by Jones and Jackson (2010), which claimed that both the decision and the intensity of observations should be determined by a multidisciplinary team and undertaken via a risk assessment. The current study identified that in terms of observing patients all staff members must always be vigilant and know the whereabouts of the patients.

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The findings of the study indicated that when it came to discharges on Wednesday and Thursdays, increased visibility of staff among the patients was needed to increase observations. In contrast, a study by Jones & Jackson (2010), claimed that special observations were employed to prevent absconding, while others claimed that they were predominantly employed for the prevention of self-harm, but also to prevent danger to self, property or others, and risk of absconding.

The shortage of nursing staff in acute psychiatric wards makes it difficult for them to carry out one-on-one or close observations. The findings also reveal that nurses feel that they should be vigilant at all times for patients who are at risk of absconding in an acute care setting to ensure patient safety; they also provide an escort for patients for all tests outside of the main psychiatric setting and, where possible, to reorientate a patient on their return. The study also identified that patients need to be accompanied whilst they go on walks; also, attending occupational therapy and group sessions will reassure the patient, making them feel safer in the environment and more comfortable in the mental health setting.

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Findings of Happell and Harrow (2010), who interviewed six registered mental health nurses, revealed that constant or special observation involved six practices: intervening; maintaining the safety of the individual and others in the ward; prevention; de-escalation; management of aggression and violence; assessing; and therapy. The findings of the research evidence indicate a need for the nursing staff, assisted by security staff, always to be visible among the patients and to carry out, regular checks among the patients, including in bathrooms and sleeping quarters, to watch for any potential risk of absconding.

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5.5 Conclusion

This study explored nurses' assessment and management of patients at risk of absconding from an acute psychiatric ward in the Western Cape, and adds to the understanding of patient safety in the mental health setting. The discussion of the findings shows that the nurses' experiences mentioned in the interviews provide guidance on how to deal with the risk of absconding. The next chapter will discuss the limitations, recommendations and conclusion of this study.

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CHAPTER SIX

LIMITATIONS, RECOMMENDATIONS AND CONCLUSION

6.1 Introduction

The research findings of this study were discussed in the previous chapter. The objectives of this study were to explore and describe nurses' experiences of assessment and management of patients at risk of absconding from acute psychiatric wards. Chapter Five discussed the findings with reference to the evidence in the relevant literature. This chapter provides the limitations, recommendations and conclusion drawn from the findings of this study.

6.2 Limitations of the study

A qualitative approach allows for the exploration of a subject where there is limited previous research. Although this approach proved to be valuable, the data were limited by the number of participants purposively selected for interviews. Therefore, the results are not generalisable to other similar populations. However, they do offer new insights into mental health nurses' experiences of patients at risk of absconding, and in particular their assessment of risk of absconding using clinical presentation and management strategies.

6.3 Recommendations

6.3.1 Recommendations for clinical practice

The researcher recommends that a mental health care service approach to risk assessment and safety planning is required which incorporates recovery and assessment of risk of absconding.

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- Professional nurses in this psychiatric hospital, in conjunction with patients' panels, need to review their policies on risk and safety to ensure that they have a recovery risk focus, as well as ensuring that the policies reflect a comprehensive definition of risk.
- A common language of risk is developed so that both professional nurses and MHCUs have at least a common understanding of what is meant by terms such as risk assessment, risk management, safety planning and positive risk.
- This might be underpinned by the adoption of a best practice guide to assist nurses to work with risk and safety in a recovery-oriented manner, and a risk glossary that can be given to professional nurses, MHCUs, families and carers. A coherent approach to the development of documentation, including a risk screening and other risk guides is required. This may involve selection and adoption of named, validated instruments throughout mental health services which will require detailed discussion to arrive at a consensus on which tools should be employed.
- A standardised risk screening tool and care plan template should be developed that can be used across all services and evaluated from all stakeholder perspectives. Any tool/template should be multidisciplinary in nature, as many of the issues will require multidisciplinary input, and incorporate a space for MHCUs to sign off on the plan.
- It is recommended that the hospital management employ more nursing staff to increase nursing staff levels to balance the nurse: patient ratio. Having more nursing staff would decrease the risk of patients absconding and ensure better observation of patients.

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6.3.2 Recommendations for management (policy makers)

National guidelines are required to inform the development of evidence-based policies and strategies for risk assessment and safety planning at organisational and clinical practice levels:

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- Policies and procedures in place for preventing and responding to absconding need to be in place and need to be up to date with current legislation and best practices.
- There should be policies and strategies that support safety by preventing absconding, which need to be implemented and enforced consistently among all patients on the unit.
- Nursing assessment and management practices should include close therapeutic relationships, educating and engaging with relatives, telephoning patients at home, controlled home visits (resources permitting), careful breaking of bad news, regular checking of urine for cannabis use, multidisciplinary reviews, treatment strategies to cope with anger and conflict, more intensive social interventions, adequate preparation and psycho-education prior to granted leave of absences.
- The problem of substance abuse requires focused and appropriate acute and rehabilitative services. Community resources need to be enhanced and aligned with tertiary services, so that a complementary and cohesive relationship is maintained.
- Risk assessment and management need to be put into human resource and epidemiological perspectives.

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6.3.3 Recommendations for training

Risk assessment and safety planning education and training should be developed and delivered to mental health practitioners:

- This would enable practitioners to develop skills to work with and respond to patients presenting with risk issues in a competent, creative and compassionate manner, including the knowledge, skills and attitudes to discuss protective factors and positive risk-taking opportunities. Patient and family/carer input should be incorporated into such training in order for professionals to recognise the potential impact on patients and family members of decisions made regarding risk and safety planning.

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- Patients' capacity to formulate self-directed plans should be built up through educational interventions as well as that ensuring training focuses on the requisite knowledge and skills of professional nurses who need to engage in the process of person-centered planning.

6.3.4 Recommendations for further research

The researcher recommends that further research be done as follows:

- More research is needed on a larger scale on the prevalence of patient assessments and management for patients at risk of absconding from acute psychiatric units. This will allow hospital managers to quantify and determine the steps for dealing with patients at risk of absconding.
- Further research should be conducted on the assessment guides and management strategies of absconding among professional nurses in other mental health facilities in an acute psychiatric ward in the Western Cape.
- Ongoing research is recommended on nurses' experiences of the assessment and management of patients at risk of absconding from other units, such as in forensic psychiatry and intellectual disability units, in order to have a comprehensive picture of how nurse's experiences MHCUs across the entire psychiatric hospital.
- There are considerable gaps in knowledge on all aspects of risk and safety, and it is therefore recommended that further studies are undertaken to explore patients', family members' and other practitioners' perspectives on and practices in risk assessment and safety planning.

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6.4 Conclusion

The conclusion of this study is discussed in line with the three major themes that emerged during data analysis of nurses' experiences of the assessment and management of patients at risk of absconding from an acute psychiatric ward. The three major themes that emerged were risk assessment, risk management, and increased observations.

Risk assessment: Participants described that a risk assessment took place on admission to an acute psychiatric ward. In this particular psychiatric hospital, the nature of that assessment was laid down by policy through using risk assessment forms. Also, risk assessment was a continuous process throughout admission to the acute psychiatric ward. Clinical judgement of risk had to be made and again once a patient presented as high risk of absconding. This would take into account the behaviour and speech content of the patient during the previous week and past 24 hours, as well as the history of the patient, perhaps over many years of psychiatric treatment.

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Risk management: One-on-one observations, close supervision and increased visibility of nursing staff as a policy were used to increase observation measures for patients at risk of absconding. Containment measures included locking the ward doors and the use of seclusion rooms as prescribed by a doctor. There were male and female psychiatric units in this particular psychiatric hospital where all ward doors are kept locked all the time. However, locking ward doors is not supported by many researchers, as discussed in Chapter Five.

Increased observations: The majority of participants were convinced that increased nursing staff levels and constancy would decrease the risk of patients absconding. This was not solely because they felt that patients would be better observed by staff, but also because they would be better able to recognise them, because they felt that nurses would then have time to get to know the patients properly as people.

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This study met its research objectives and provide answers on nurses' assessment and management for patients at risk of absconding from an acute psychiatric ward. The results of the study will be communicated to relevant stakeholders and decision-making bodies and will be communicated to the Department of Health of the Western Cape as a report for disseminating of the research findings.

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APPENDIX A

Interview Guide Questions

1. Please explain your experiences of how the risk of patients absconding is assessed at your acute psychiatric ward.

Probing: How are the risk factors or characteristics of patients may abscond assessed?

2. Could you explain your experiences of the use containment measures in the management of patients at risk of absconding in an acute psychiatric ward?

Probing: Tell me more about the use of chemical and physical restraints, locking of doors and seclusion rooms.

3. Could you explain your experiences of the use of increase observations measures in the management of patients at risk of absconding in your acute psychiatric wards?

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APPENDIX B

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-850 4722 Fax: not applicable

E-mail: 2529611@mywuc.ac.za

CONSENT FORM

Title of Research Project: Exploration of nurses experiences of the assessment and management for patients at risk of absconding from an acute psychiatric ward in the Western Cape.

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The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

Participant's name……

Participant's signature……

Date……

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APPENDIX C

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-850 4735 Fax: Not applicable

E-mail: 2529611@myuwc.ac.za

03 October 2016

INFORMATION SHEET

Project Title: Exploration of nurses experiences of the assessment and management for patients at risk of absconding from an acute psychiatric ward in the Western Cape.

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What is this study about?

This is a research project being conducted by Fikile .N Malgas student no 2529611at the University of the Western Cape. I am inviting you to participate in this research project because you have experiences working with absconding psychiatric patients. The purpose of this research project is to explore and describe the experiences of nurses on the assessment and management practices of patient at risk of absconding in acute psychiatric wards.

What will I be asked to do if I agree to participate?

You will be asked to explain how the assessment and management of absconding patients be conducted in your acute psychiatric ward? What are the best practices in the management of absconding patient?

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Would my participation in this study be kept confidential?

To ensure your confidentiality, the information regarding participants during the process of research will not be disclose to anyone or institution, will only be available to the researcher and the supervisor, having locked filing cabinets and storage areas, using identification codes and using password-protected computer files.

If we write a report or article about this research project, your identity will be protected. In accordance with legal requirements and/or professional standards. We will disclose to the appropriate individuals and/or authorities information that comes to our attention concerning child abuse or neglect or potential harm to you or others. In this event, we will inform you that we have to break confidentiality to fulfil our legal responsibility to report to the designated authorities.

What are the risks of this research?

There may be some risks from participating in this research study. All human interactions and talking about self or others carry some amount of risks. We will nevertheless minimise such risks

and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

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What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator learn more about assessments and management of patients at risk of absconding. We hope that, in the future, other people might benefit from this study through improved understanding of assessments and management strategies of patient at risk of absconding.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

<u>Audio taping</u>

This research project involves making ***audiotapes*** of you to capture the information accurately, and not to miss relevant information. The recorded information will be

http://etd.uwc.ac.za

kept in a locked cabinet, and once information will be transferred into the computer it will be protected with password. After the process of research completed all the recorded information will be destroyed.

___ I agree to be audiotaped during my participation in this study.

___ I do not agree to be audiotaped during my participation in this study.

What if I have questions?

This research is being conducted by Fikile Nelson Malgas ; department of nursing at the University of the Western Cape. If you have any questions about the research study itself, please contact Mr FIkile N Malgas at: No 18 , 19th street , Broadlands , Strand , 7140; contact no : 021-8504722 / 0732913317 , e-mail 2529611@myuwc.ac.za.

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact: Prof. Karien Jooste

Head of Department

University of the Western Cape

Private Bag X17

Bellville 7535

kjooste@uwc.ac.za

Prof José FrantzDean of the Faculty of Community and Health Sciences

University of the Western Cape

Private Bag X17

Bellville 7535

chs-deansoffice@uwc.ac.za

This research has been approved by the University of the Western Cape's Senate Research Committee. (REFERENCE NUMBER: *to be inserted on receipt thereof from SR*)

UNIVERSITY of the WESTERN CAPE

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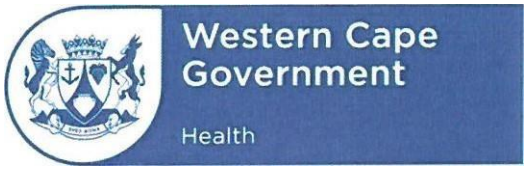
APPENDIX D



STRATEGY & HEALTH SUPPORT Health-Research@westerncape.gov.za tel: +27 21 483 6857: fax: +27 21 483 9895 5th Floor, Norton Rose House,, 8 Riebeek Street, Cape Town, 8001 www.capegateway.gov.za)

REFERENCE: WC 2016RP49 567
ENQUIRIES: Ms Charlene Roderick

University of the Western Cape

Robert Sobukwe Road

Bellville

Cape Town

7535

For attention: Mr Fikile Nelson Malgas

UNIVERSITY of the
WESTERN CAPE

Re: Exploration of nurses experiences of the assessment and management for patients at risk of absconding from an acute psychiatric ward in the Western Cape.

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact following people to assist you with any further enquiries in accessing the following sites:

Lentegeur Hospital	Nadine Jacobs	021 370 1105

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.

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2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (annexure 9) within six months of completion of research. This can be submitted to the provincial Research Co-ordinator

(Health.Research@westerncape.gov.za)

3. In the event where the research project goes beyond the estimated completion date which was submitted, researchers are expected to complete and submit a progress report (Annexure 8) to the provincial Research Co-ordinator Health.Research@westerncape.gov.za .

4. The reference number above should be quoted in all future correspondence.

Yours sincerely

AT HAWKRIDGE.

DR A HAW IDC

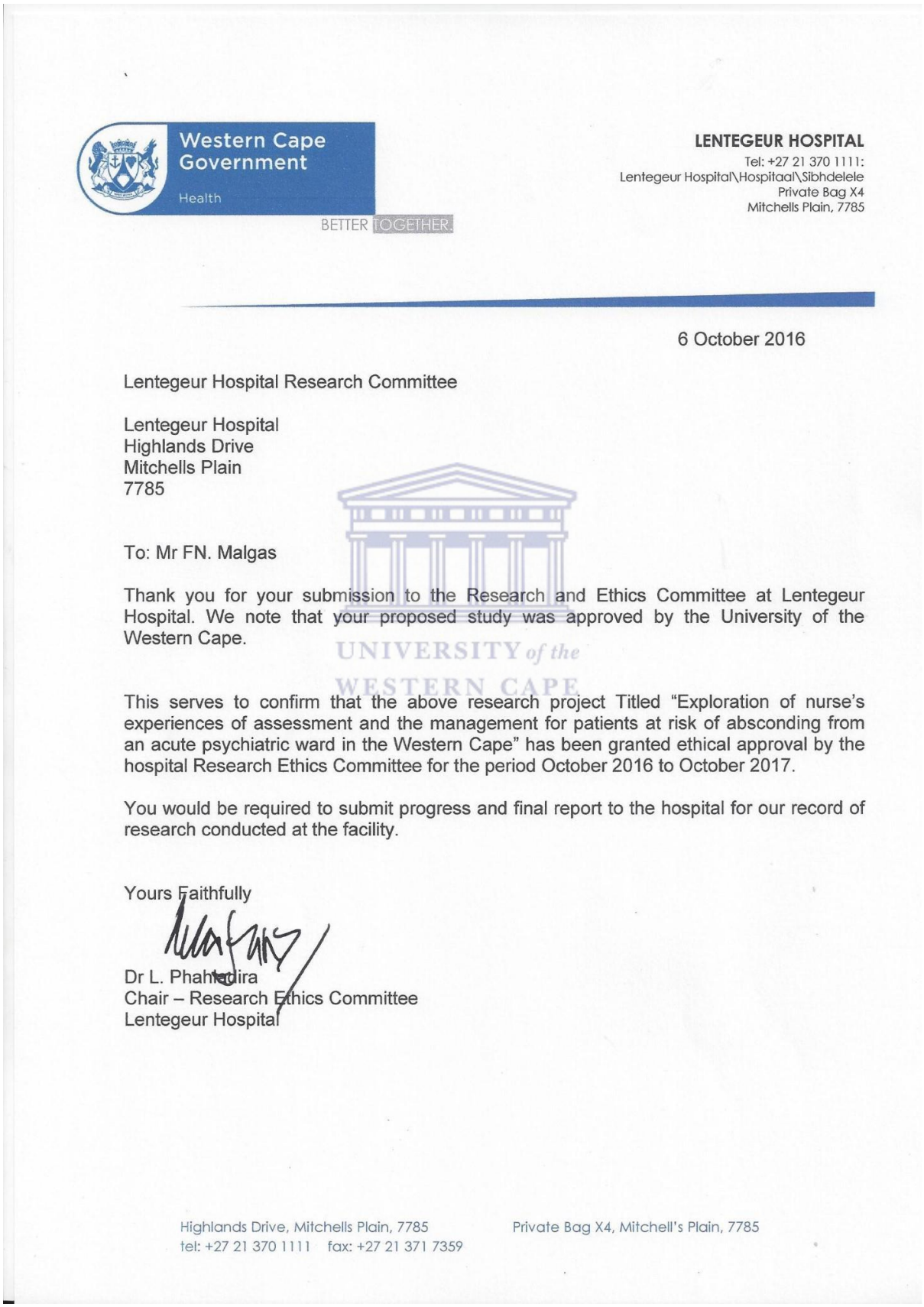
DIRECTOR: HEALTH IMPACT ASSESSMENT

DATE: 11/10/2016.

UNIVERSITY of the WESTERN CAPE

http://etd.uwc.ac.za

APPENDIX E



Western Cape Government
Health
BETTER TOGETHER.

LENTEGEUR HOSPITAL
Tel: +27 21 370 1111:
Lentegeur Hospital\Hospitaal\Sibhdelele
Private Bag X4
Mitchells Plain, 7785

6 October 2016

Lentegeur Hospital Research Committee

Lentegeur Hospital
Highlands Drive
Mitchells Plain
7785

To: Mr FN. Malgas

Thank you for your submission to the Research and Ethics Committee at Lentegeur Hospital. We note that your proposed study was approved by the University of the Western Cape.

UNIVERSITY of the
WESTERN CAPE

This serves to confirm that the above research project Titled "Exploration of nurse's experiences of assessment and the management for patients at risk of absconding from an acute psychiatric ward in the Western Cape" has been granted ethical approval by the hospital Research Ethics Committee for the period October 2016 to October 2017.

You would be required to submit progress and final report to the hospital for our record of research conducted at the facility.

Yours Faithfully

Dr L. Phahladira
Chair – Research Ethics Committee
Lentegeur Hospital

Highlands Drive, Mitchells Plain, 7785
tel: +27 21 370 1111 fax: +27 21 371 7359
Private Bag X4, Mitchell's Plain, 7785

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APPENDIX F

UNIVERSITY of the WESTERN CAPE

OFFICE OF THE DIRECTOR: RESEARCH
RESEARCH AND INNOVATION DIVISION

Private Bag X 17, Bellville 7535
South Africa
T: +27 21 959 2988/2948
F: +27 21 959 3170
E: research-ethics@uwc.ac.za
www.uwc.ac.za

06 September 2016

Mr FN Malgas
School of Nursing
Faculty of Community and Health Science

Ethics Reference Number: HS/166/9

Project Title: Exploration of nurses' experiences of assessment and the management for patients at risk of absconding from an acute psychiatric ward in the Western Cape.

UNIVERSITY of the
WESTERN CAPE

Approval Period: 24 August 2016 – 24 August 2017

I hereby certify that the Humanities and Social Science Research Ethics Committee of the University of the Western Cape approved the methodology and ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval. Please remember to submit a progress report in good time for annual renewal.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

PROVISIONAIREC NUMBER – 130416049

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