

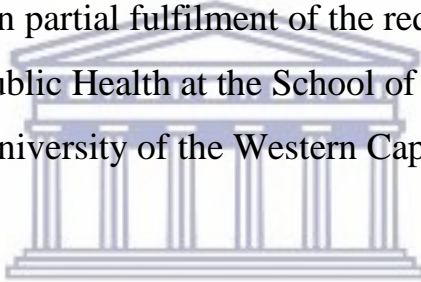
**An exploration of the perceptions of nurses in caring for
psychiatric patients in a rural district hospital in Northern Cape,
South Africa.**

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A mini-thesis submitted in partial fulfilment of the requirements for the degree
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DECLARATION

I declare that, “*An exploration of the perceptions of nurses in caring for psychiatric patients in a rural district hospital in Northern Cape, South Africa*” is my own work. It has not been submitted for any degree or examination in any other university before. All sources I have used or quoted have been indicated and acknowledged by complete references.

Full Name: Tsietsi Martin Matsoso

Date: 10 April 2017

Signed:



T.M Matsoso



DEDICATION

This study is dedicated to all the nurses caring for psychiatric patients under very difficult circumstances, that include but are not limited to unfit-for-purpose infrastructure, shortage of staff, lack of education, training and support.



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ABSTRACT

Caring for psychiatric patients in the medical wards of rural district hospitals is of concern, as the hospitals are not designed to make provision for these patients. Psychiatric patients, especially those diagnosed with severe mental illnesses, such as schizophrenia and bipolar mood disorders may exhibit disruptive and aggressive behaviour which may be overwhelming to other patients who are not suffering from mental illness. The aim of the study was to explore the perceptions of the nurses caring for psychiatric patients in a rural district hospital, in order to gain a deeper understanding of their concerns and their experiences.

An exploratory qualitative study design was undertaken. Purposive sampling was used to select nurses as study participants to answer the research question. A total of eight nurses were interviewed. Four out of eight participants were professional nurses, three of which were trained in psychiatric nursing and one trained in general nursing and midwifery; one enrolled nurse and three assistant nurses. The selection criteria included nurses that have been employed for at least six months in the district hospital and had an experience of working with psychiatric patients. The researcher requested permission from the hospital manager to contact nurses in person from their workplaces. After the permission was granted, the researcher approached the nurses individually and explained the purpose of the research study. He also requested them to take part in the study. Data was collected using one-on-one and face-to-face in-depth interviews. Thematic Coding Analysis was used to analyse the data by coding it, clustering similar codes together, clustering codes into emerging themes and analysing the patterns and links between the themes.

The study received ethical approval from the Ethics Committee of the University of Western Cape and the study participants were requested to participate voluntarily after giving informed consent and confidentiality and anonymity was assured. They were also advised that they could

withdraw at any stage if they desired. The collected data was only used for the intended purpose.

The study found that the psychiatric patients' behaviour especially that of the uncomfortable nature was a result of the effects that working in a rural district hospital has on the nurses and that the nurses lack skills and knowledge and are affected by infrastructural and human resources factors. Nurses experienced violence, aggression, strange behaviours and some of the patients roamed around. They indicated that the psychiatric patients who displayed such behaviours are difficult to work with and that makes them uncomfortable. Very few positive statements emerged from the nurses with regard to the manner in which they experienced mentally ill patients in a ward or unit.

The nurses felt that the lack of knowledge and skills required to care for mentally ill patients evoked a negative self-perception. They regarded themselves as being inadequately equipped to effectively care for psychiatric patients. They also admitted that knowledge and therapeutic skills were necessary for nursing mentally ill people, which are factors that they feel they do not have. They, therefore, proposed that they have a structured training programme or workshop, where staff will learn nursing skills regarding caring for psychiatric patients on a continuous basis. Lack of support was another area of concern for the nurses. They felt that they are not being supported by their managers, the security guards, the mental health specialist team nor the guidelines in the absence of managers and the mental health specialist team.

Apart from the behaviour of the patients, nurses were also concerned about the unit or ward in which they nurse mentally ill people. The issues of staff shortage and overcrowding were also mentioned as additional problems that made it difficult to render adequate nursing care to mentally ill people.

While the environment posed a serious problem to the recovery of mentally ill people in a district hospitals' medical wards, nurses' feelings were another issue. Nurses expressed a

feeling of fear with regard to caring for a psychiatric patient in a medical ward of a district hospital. They were mostly concerned about their own safety.

Participants had different opinions about the admission of psychiatric patients in medical wards. There were three strong opinions on what could be done to resolve the problem. They suggested training for them to be able to care for psychiatric patients in their wards. Secondly, they suggested that patients should be separated so that psychiatric patients can have a fit-for-purpose infrastructure. Lastly, they suggested that there should be additional nursing staff in the unit to augment the current compliment.



CHAPTER 1

INTRODUCTION

1.1 Overview of mental health services

Mental health has over many decades acquired the unwelcome reputation of being a pariah or stepchild of the health services. This is partly because it was narrowly understood as a psychiatric illness, an area of concern for only psychiatrists, psychiatric nurses, patients and their families (Masilela, 2000). The World Health Organisation (WHO) has drawn attention to the growing global burden of mental health disorders and to recent advances in the understanding of and ability to treat these disorders. Mental health disorders accounted for 12% of the global burden of disease in 2000 and it is estimated that this figure will rise to 15% in 2020. It is also estimated that unipolar depression will be the second most disabling health condition in the world in the same year (WHO, 2001).

In South Africa, neuropsychiatric disorders are ranked third in their contribution to the overall burden of disease after Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) and other infectious diseases (Bradshaw, Norman & Schneider, 2007). The first nationally representative psychiatric epidemiological study, the South African Stress and Health (SASH) survey (2007) found that 16.5% of adults have experienced a mood, anxiety or substance use disorder in the previous 12 months. The 12-month prevalence of child and adolescent mental disorders in the Western Cape was reported to be 17%, based on a review of local and international epidemiological literature (Kleintjies *et al.*, 2006).

Prior to 1994, mental health services in South Africa followed the colonial system of health care delivery which was tertiary hospital-based (Peterson, Bhana, Campbell-Hall, Mjadu, Lund, Kleintjies, Hosegood & Flisher, 2009). Burns (2008) attributes the hospital-based mental health services to the Mental Health Act (MHA) No. 18 of 1973, which focused on the control and treatment of patients. The MHA reinforced the separation of mental health care from general health care. Psychiatric services were made to be stand-alone entities and were not integrated into primary health care. Psychiatric services were also centralised in urban-based tertiary psychiatric institutions, far from the homes and communities of most patients. Mental illness in a rural village or remote town often meant being transferred to hospitals that were

very far and there would be a lengthy incarceration far from home, family and place of employment. There was little or no care within the community (Burns, 2008).

However, to align with international developments in mental health care, the first post-apartheid mental health policy was approved in 1997. This policy took the form of a document titled, 'National Health Policy Guidelines for Improved Mental Health in South Africa' (DOH 1997). A chapter on mental health was also included in the Department of Health's 'White Paper for Transformation of the Health System in South Africa' (DOH, 1997a). Later, a National Mental Health Policy Framework and Strategic Plan 2013 – 2020 was developed (DOH, 2013). All these papers advocated for community-based mental health services.

Subsequently, the Mental Health Care Act (MHCA) (2002) was promulgated in 2004 with its core principles based on human rights for users; decentralisation and integration of mental health care into primary health care and a focus on care, treatment and rehabilitation. Madlala and Sokudela (2014) assert that the Mental Health Care Act, no 17 of 2002 promotes the provision of community-based mental health services and thus, makes provision for psychiatric patients to be admitted to a district general hospital. Furthermore, the Mental Health Care Act, no 17 of 2002 prescribes admission procedures, with more emphasis on the full physical and psychological assessment of a mentally ill person. It also allows for treatment to be initiated as soon as possible and referral of persons still in need of inpatient care to psychiatric facilities must be done after 72 hours.

However, the task of implementing the requirements of the Act at district hospital levels is fraught with problems. Problems experienced include lack of dedicated wards for mental health care users, lack of properly trained staff to manage psychiatric patients and a shortage of medications (Burns, 2008).

1.2 Study context

The focus of the research was in one of the district hospitals based in the District Management area of Pixley ka Seme District, which is where the researcher is based. The district lies in the south-east part of the Northern Cape Province and shares borders with three other provinces, namely, the Free State to the east, the Eastern Cape to the south-east and the Western Cape to the south-west. It is one of the five district municipalities in the province and it is the second largest covering a total surface area of 102 727 square kilometres. The District Municipality's demarcated areas comprise of eight Category B Municipalities and one District Management

Area. The eight Category B Municipalities also form the sub-district for the health district. The district has a population of 191 078 of which 58.3 percent are below the age of 30 and 84.2 percent of the total population do not have health insurance (Massyn, Day, Peer, Padarath, Barron & English, 2013). According to Statistics South Africa (Stats S.A.) (2011), 28.3 percent of the district population is unemployed and according to a Community Survey (2007), 10 percent of the households live with an annual income of below R4 800 per month, 15.8 percent of the households live in informal dwellings, 95 percent of the households have access to sanitation, 91 percent of the households have access to potable water and 88.9 percent of the households have access to electricity. The district comprises of three district hospitals, eight community health centres, 28 fixed primary healthcare facilities (clinics), satellite clinics and one mobile clinic (DHP, 2014). All these health facilities render mental health services at different levels. The district hospitals are the only health establishments with inpatient mental health services, as they are the only ones admitting psychiatric patients.

The district hospital where the study took place is a small hospital with a 50 bed capacity. The hospital consists of a mixture of health professionals, with nurses making the majority of healthcare providers. Among the nurses, there are different categories, namely, professional nurses, staff nurses and auxiliary nurses. Furthermore, among the professional nurses, there are those who were trained and others who were not trained in psychiatry. The district hospital has different units/wards that include paediatric unit, theatre, accidents and emergency unit, male and female wards. Psychiatric patients are admitted in male and female wards together with other patients who have other medical conditions.

1.3 Problem Statement

With the implementation of the Mental Health Care Act, no 17 of 2002 all health establishments including district hospitals are compelled to admit acute psychiatric patients for 72 hours without consent for assessment and observation. Traditionally, psychiatric care was not part of the general district hospital healthcare delivery package. The admission of acute psychiatric patients and those with medical conditions in the same units came with new challenges for the healthcare team (Thupayagale-Tshweneagae & Ganga-Limando, 2014). Psychiatric patients, especially those diagnosed with severe mental illnesses such as schizophrenia and bipolar mood disorders may exhibit disruptive and aggressive behaviours which may be overwhelming for other patients (Lethoba, Netswera & Rankhumise, 2006).

A concern has been raised at this rural district hospital that given the nature of behaviours exhibited by psychiatric patients, it is often difficult to care for them because some of the nurses have no knowledge of how to handle disruptive and aggressive psychiatric patients as their training did not include psychiatry (Conversation with the Nursing Services Manager). Most of the studies conducted around this issue were conducted in bigger hospitals in urban areas (Mavundla & Uys, 1997; Mavundla, Poggenpoel & G'meiner, 1999; Reed & Fitzgerald, 2005). There is a lack of information, especially in South Africa regarding caring for psychiatric patients in rural district hospitals.

1.4 Purpose of the Study

The purpose of this study was to explore perceptions of nurses working in a rural district hospital on caring for psychiatric patients in order to gain a deeper understanding of their concerns and experiences. The researcher intends to make recommendations to the district management based on the findings of the study.



CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

Chapter 2 will discuss the review of the literature pertaining to the study using the thematic method. The search for relevant data began with the identification of terms within the study topic of nurses' experiences in caring for psychiatric patients in general hospitals. Computer searches of PubMed, Ebscohost and Medline were used to search and retrieve research and non-research articles. Books and monographs were also used. The themes that surfaced from the search were nurses' perceptions, attitudes and the aggression of psychiatric patients. The literature also focused on mental health, mental illness, social causes of mental illness, how mental health is treated and challenges with treating mental illness.

2.2 Mental health

Health is defined by the WHO as, "a state of complete physical, mental and social well-being" (WHO, 1948). Mental health is, therefore, an essential element of health and is crucial to the overall well-being of individuals and society. Mental health is defined as, "...the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people and the ability to adapt to change and to cope with adversity; from early childhood until later life, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self-esteem" (WHO, 2005:2). However, mental health and mental illness are believed to be outgrowths of intrapersonal (within the mind or self) and interpersonal (between self and others), processes (Kneisl & Trigoboff, 2009).

2.3 Mental illness and social causes

Mental illness, also referred to as mental disorder, is defined by Kneisl and Trigoboff (2009:6) as, "A psychological group of symptoms, such as a pattern or a syndrome, in which an individual experiences distress (a painful symptom), disability (impairment in one or more important areas of functioning), or a significant increased risk of suffering, pain, loss of freedom, or death". According to the Mental Health Care Act, No. 17 of 2002, mental illness means "...a positive diagnosis of a mental health related illness in terms of accepted diagnostic criteria made by a mental health care practitioner authorised to make such diagnosis". In most

countries, the definition of psychiatric illness must meet the diagnostic criteria stipulated in Diagnostic and Statistical Manual, fifth edition (DSM-5).

The definitions of mental illness or disorder are at times questioned. As a result, Stein *et al* (2010) argues that mental illness remains blurred even today and the only feature acknowledged is that there is prolonged instability (emotional and psychological) among persons deemed to have mental illness.

Over the years, different theories have been proposed regarding the causes of mental illness. Amongst others (i.e., biopsychosocial and stress vulnerability theories), socioeconomic factors, especially poverty, are said to influence mental health in powerful and complex ways. They are highly correlated with an increase in the prevalence of serious disorders such as schizophrenia, major depression, antisocial personality disorders and substance use. Most of these disorders are about twice as common among the poorest sections of society as in the richer ones. The relationship between poverty and mental ill-health has been described as a “vicious cycle” (Patel, 2001). People living in poverty are at increased risk of developing mental disorders through the stress of living in poverty, lack of social support, exposure to violence and poor physical health (Flisher et al, 2007). On the other hand, those who live with mental illness are at risk of sliding into or remaining in poverty, as a result of increased health expenditure, lost income, reduced productivity, lost employment and social exclusion due to stigma (Flisher et al, 2007). In addition, malnutrition, infectious diseases and lack of access to education can be risk factors for mental disorders and can worsen existing mental problems (WHO, 2001).

2.4 Current mental health service provision in Sub-Saharan Africa

The challenge of meeting population needs for mental health interventions across a country within the context of scarcity of specialist human resource faces all countries, but it is most challenging in low-income countries (Jenkins, Kiima, Okonji, Njenga, Kingora & Lock, 2010). Recent research has revealed the extent to which mental health care in many low and middle-income countries is consistently under-resourced (Jacob, Sharan, Mirza, Garrido-Cumbrera, Seedat, Mari, Screenivas & Saxena, 2007). This is further compounded by the fact that mental health care is often one of the lowest health priorities for low-income countries (Ofori-Atta, Read & Lund, 2010). For instance, the burden of mental disorders in Uganda is high and the country is poorly resourced. The majority of the population is rural and still harbours negative cultural beliefs (Ndyabangi, Basangwa, Lutakome & Mubiru, 2004). In terms of mental

health service provision, the Uganda Ministry of Health mandates that there be at least one encoded psychiatric nurse with a 2-year certificate at the outpatient village level and that services at the health centres employ clinical and medical officers, however, there are many vacancies at both levels (Kopinak, 2015). Services at the regional referral hospitals include psychiatric units staffed by Psychiatric Clinical Officers while two national referral mental health hospitals are staffed by psychiatrists and psychologists who offer all mental health services. Private international non-governmental organisations and health facilities that offer mental health services are expensive and are in the urban areas and they tend to focus on HIV/AIDS, thereby limiting access for the majority of individuals requiring assistance (Kopinak, 2015).

Similarly, Kenya is a developing country where poverty and lack of resources are key to underdevelopment and in which mental health problems contribute enormously to poverty at both individual and family level (Kiima, Njenga, Okonji & Kigamwa, 2004). Mental illness is common in Kenya, with prevalence rates of 4% for major mental disorders. Poverty, unemployment, internal conflict, displacement and HIV add to the mental health burden (Marangu, Sands, Rolley, Ndeti & Mansouri, 2014). Mental health services in Kenya are mainly government funded, with very few privately funded programmes and facilities. Based in Nairobi, Mathari Hospital is the largest psychiatric hospital, providing inpatient services for the whole of Kenya (Marangu *et al.*, 2014). However, the WHO recommends that psychiatric hospitals be closed and replaced by services in general hospitals, community mental health services and services integrated into primary care.

2.5 District hospital mental health service

For a number of people with severe mental disorders, hospitalisation is required at some point in their lives. District general hospitals provide an accessible and acceptable location for 24-hour medical care and supervision of people with acute worsening of mental disorders. The WHO (2008) proposes that district general hospitals should have wards dedicated to the treatment of mental disorders with layouts supported by good observation and care, thereby minimising the risk of neglect and suicide. Seloilwe *et al.* (2007) support the proposal and further suggest that community-based mental health service is supposed to take an integrative approach supported by the inclusion of beds in general wards for patients with acute psychiatric conditions. However, Szabo (2013) holds an opposite view that psychiatric specific facilities are necessary, recognising the unique requirements of psychiatric patients whereby co-opted

medical wards in hospital settings are simply not adequate. Zuzelo, Curran and Zeserman (2012) support the idea of psychiatric specific facilities as they value what they refer to as ‘therapeutic milieu’. They assert that the milieu serves as the group setting in which therapeutic interventions are based on consistency, security, trust and modelling aimed at influencing the attainment of a positive patient outcome.

2.6 Challenges with district mental health service

Mavundla and Uys (1997) acknowledge that development of general hospital psychiatry created difficulties for staff members. The authors also raised a concern that the needs of mentally ill people may not be adequately met in these settings, considering the fact that when a patient is admitted to any general hospital department where they were once hospitalised for mental illness, their present problems may not be seriously considered even if their mental illness is well controlled. Furthermore, a study by Mavundla, Poggenpoel and G’meiner (1999) discovered that most nurses were negative about the care of mentally ill patients in these settings as they perceived themselves to be inadequately prepared. As a result, the negative attitudes directly influence the nurses’ ability to provide care (Reed & Fitzgerald, 2005).

2.6.1 Psychiatric patients’ behaviour

Psychiatric patients are often characterised as being aggressive, violent, disruptive and displaying strange behaviours (Mavundla, 2000; Lewis and Dehn, 1999). Violence, particularly by psychiatric patients has long been recognised as a significant and increasing problem in psychiatric settings (Mulvey, 1994). Bowers *et al* (2005) further add absconding and refusal of medication as what they refer to as, ‘conflict behaviours’. Furthermore, Ballerina *et al* (2007) in their observational study on psychiatric acute patients admitted to general hospital psychiatric wards in Italy, found that the main reason for admission was a severe psychotic episode with a diagnosis of schizophrenia and most psychiatric patients presented aggressive behaviours. Foster *et al* (2006) postulate that aggression can be expressed in many forms, ranging from a patient raising their voice during an argument to an unprovoked violent attack involving a weapon. However, Cammucio *et al* (2011) claim that although the phenomenon of aggressiveness and violence in psychiatry and mental health settings has been studied widely, the causal relationship between psychiatric disease and violence is still unclear. On the contrary, Duxbury (1999) attributes patients’ aggressive outburst to internal factors such as frustration and fear. McGeorge *et al* (2000) as cited by Foster, Bowers and Nijman (2006),

further expand the attribution of aggression on inpatient psychiatric wards to the greater levels of symptom severity and frustration at removal of rights, in combination with the poor physical environment of many wards, deprived social environments and low staff morale.

Jansen *et al* (1997) identified three distinct perceptions of aggression, that is, aggression as a normal reaction to feelings of anger, aggression as a violent and threatening reaction and aggression as a functional reaction. The authors make an assumption based on the findings of their study that, nurses who work in an environment where seclusion and fixation are applied are likely to perceive aggression as a violent and threatening reaction. As a result, Breeze and Rapper (1998) in their study named, *Struggling for control, the care experiences of 'difficult' patients in mental health services*, point out that aggression, violence, self-harm and disruptive behaviour appear to be common characteristics of patients who the nurses considered the most difficult. They also noted that the patients' wandering behaviour outside the ward may lead to patients getting lost or running away and the issue of noise that causes a disturbance in the quiet environment of the hospital, added to the problems nurses are faced with.

Furthermore, Mavundla's (2000) findings revealed that general nurses stated that mentally ill patients displayed bizarre behaviour which they are not familiar with, such as walking around naked. As a result, such behaviour by some of the psychiatric patients was emotionally taxing for the study participants as they were concerned about their personal physical safety and their overall well-being (Jackson & Morrisette, 2014). It was also noted that, the issue of gender in relation to patient aggression was an issue. Kindy, Petersen and Parkshurst (2005:169) suggest that there might be a perception that either positive or negative attitudes have an impact on how nurses experience caring for psychiatric patients. This attitude is suspected to emanate from the nurses' personal meanings about psychiatric patients. The authors further noted that the personal meanings of nurses working in assaultive environments and how they perceive the consequences for their professional lives are missing from the literature.

2.6.2 Lack of knowledge and skills on how to care for psychiatric patients

Many studies have reported that nursing psychiatric patients needs training, skill and knowledge. These studies have been reported in the last three decades and the findings remain the same. Mavundla's (2000) findings on nurses' perceptions of patients in a general hospital setting was that possession or a lack of knowledge and skills to nurse mentally ill patients in general hospital settings determined the nurse's perceptions of the mentally ill patient. The author further points out that nurses are of the opinion that nurses trained in psychiatry would have positive perceptions as compared to nurses who would have negative perceptions because of lack of knowledge on how to deal with the mentally ill patient. Furthermore, nurses viewed the presence of psychiatric patients as an impediment that was going to meddle with their duties and most nurses acknowledged their ignorance of mental illness.

Thupayagale-Tshweneagae and Ganga-Limando (2014) in their study, "exploring general registered nurses' concerns with the management of acute psychiatric patients in a general hospital" found that, all participants verbalized a lack of knowledge and skills in caring for psychiatric patients. Furthermore, Gule (2013) in her dissertation project titled, *Lived experiences of general nurses working in Standerton Hospital medical wards designated to be a 72-hours assessment for psychiatric patients*, found that all participants esteemed the fact that caring for psychiatric patients is totally different from caring for medical patients. They emphasised a lack of knowledge and skills necessary for nursing psychiatric patients. Similarly, a study by Sharrock *et al* (2005) also revealed that general nurses perceive themselves as lacking knowledge in assessment and management of psychiatric patients and that it is difficult for them to render care that will meet the patients' needs.

Lethoba *et al.* (2006) in their study on how professional nurses in a general hospital setting perceive mentally ill patients found that, most nurses in general wards were not trained in psychiatry, which made the situation worse. Many nurses reported that they did not have adequate knowledge or skills to identify, assess and treat patients with mental illness (Clark, Parker & Gould, 2005).

Bates, Smith and Brunero (2006) acknowledge that caring for patients suffering from psychiatric conditions requires knowledge and understanding of their various behavioural patterns and knowledge on how to cope. The authors further acknowledge that specific techniques of all types of problematic behaviours need to be learned by the nurses in order to provide skilled therapeutic care for these patients. This presupposes that psychiatric nursing is

a specialised field, which requires specific specialised training. This is important as the nursing care of psychiatric patients typically differs substantially from nursing patients in general wards, where the patients are mostly considered easier to work with and are also considered to show faster improvement than psychiatric patients (Gule, 2013).

2.6.3 Infrastructural factors

According to Bywood, Brown and Raven (2015), infrastructure can be considered in terms of physical resources (e.g. sufficient space in a practice) and workforce resources (e.g. capacity building, training). For the purpose of this research, infrastructure will refer to the physical environment which is where caring for psychiatric patients takes place, that is, wards in which psychiatric patients are kept and the nurses caring for such patients.

A study by Ramlall, Chipps and Mars (2010) which examines the impact of the South African Mental Health Care Act, No. 17 of 2002 on regional and district hospitals designated for mental health care in KwaZulu-Natal revealed that 23 of 49 hospitals reported that they did not have appropriate or adequate facilities to provide psychiatric services as required by the Act. They discovered that common complaints were related to the lack of sufficient beds, staff and seclusion rooms to accommodate the clinical demand and the challenges of managing disruptive patients in a general hospital setting. The authors further noted that some hospitals admitted psychiatric patients to general medical or surgical wards. Furthermore, it was also discovered that some hospitals with psychiatric units had additional beds designated for psychiatric patients within general surgical and/or medical wards to cater for the overflow of admissions or the opposite gender. With regard to seclusion facilities, there was dissatisfaction reported as the existing seclusion facilities were inadequately refurbished and the medical isolation wards were doubling up as 'seclusion' facilities. This supports Burns's (2008) findings that, the deficiencies in district hospital service were related-amongst others-to inadequate facilities for containing disturbed, aggressive psychiatric patients.

Contrary to the notion of district hospitals caring for psychiatric patients, Szabo (2013) argues that psychiatry specific facilities are necessary, recognising the unique requirements of psychiatric patients whereby co-opted medical wards in hospital settings are simply not adequate. He further cautions that the need for specialist psychiatric hospitals is not about incarceration but about providing an environment that is focused and appropriate for the treatment of psychiatric patients as their capacity to make informed decisions about their own mental health care has been compromised (Janse van Rensburg, 2010).

Shortage of health professionals

Naicker *et al* (2009) point out that, in sub-Saharan Africa, there are 57 countries with a critical shortage of healthcare workers, a deficit of 2.4 million doctors, nurses and midwives. Africa has 2.3 health workers per 1000 people, compared to the Americas, where there are 24.8 healthcare workers per 1000 people. The WHO (2013) attributes this shortage to the ageing health workforce as staff are retiring or leaving for better paid jobs without being replaced, while inversely, not enough young people are entering the profession or being adequately trained. Increasing demands are also being put on the sector from a growing world population with an increase of risks of non-communicable diseases (e.g. cancer, heart disease, stroke etc.). Internal and international migration of health workers is also exacerbating regional imbalances (WHO, 2013).

Kakuma *et al* (2011) concur that many countries of low and middle-income face a health workforce crisis and further acknowledge that the scarcity of human resources and training is similarly overwhelming for mental health. In South Africa, psychiatric hospitals have some of the highest vacancy rates in the country (Cullinan, 2016). Bimenyimana *et al* (2009) argue that shortage of staff makes psychiatric nurses overwork. This results in tiredness and job dissatisfaction. Psychiatric nurses then become discouraged and even absent themselves from work as a sign of protest against the situation in which they find themselves. The authors point out that such a situation decreases the already overstretched number of staff causing more stress and anxiety to those on duty.

Due to the shortage, nurses often need to work long hours under very stressful conditions, which can result in fatigue, injury and job dissatisfaction. Nurses suffering in these environments are more prone to making mistakes and medical errors. An unfortunate outcome is that patient quality can suffer, resulting in a variety of preventable complications, including medication errors, emergency room overcrowding and more alarmingly, increased mortality rates (Medical Executive Council, 2016).

2.7 Conclusion

Most studies recognise the difficulties experienced when caring for psychiatric patients, even more so, in a district hospital. This difficulty is not only brought about by behaviours that they exhibit but also by the environment in which they are being cared for. Almost all the studies reviewed, referred to aggression, be it perceived or real, among psychiatric patients as the main

factor for endorsing negative attitudes towards psychiatric patients. All studies recounted that it was essential for nurses working with psychiatric patients to be trained.



CHAPTER 3

METHODOLOGY

3.1 Introduction

This chapter describes the research methodology used in this study. It also includes the study design and methods, the study population and the characteristics of the participants as well as sampling procedures. Measures taken to improve rigour, ethical consideration and study limitations are also discussed.

3.2 Aims and Objectives

The study aimed to explore the perceptions of the nurses caring for psychiatric patients in a rural district hospital in order to gain a deeper understanding of their concerns and their experiences.

The objectives are:

- To explore nurses' perceptions of their preparedness to look after mentally ill patients in a rural district hospital
- To explore nurses' experiences of caring for psychiatric patients in a rural district hospital
- To explore attitudes held by nurses in a rural district hospital setting towards mentally ill patients
- To identify factors influencing these attitudes
- To identify aspects that the rural district hospital can improve on to enhance caring for psychiatric patients

3.3 Study design

The research design is the set of logical steps taken by the researcher to answer the research questions. It forms the “blueprint” of the study and determines the methods used by the researcher to obtain sources of information (Brink, van der Walt & van Rensburg 2012). The research design for this study is a qualitative, explorative design. According to Bless *et al*

(2000), exploratory research is conducted to gain insight into a situation or phenomenon. The exploratory design enables the researcher to explore the perceptions of the nurses in depth and in so doing, gain insight and understanding of their concerns and attitudes.

3.3.1 Qualitative research

A qualitative research design was used for the study because it enabled the researcher to explore the nurses' perceptions in caring for psychiatric patients in a rural district hospital in an in-depth and holistic manner in order to gain insight and to discover meaning about their experiences and situations (Burns *et al*, 2008).

Responses in qualitative studies are reported to be rich, in-depth and exploratory in nature and are effective in obtaining information about culture and the social context of the population in the study (Mack *et al*, 2005).

3.4 Research population and sampling

A population is the entire group of persons or objects that are of interest to the researcher, in other words, those that meet the criteria the researcher is interested in studying (Brink *et al* 2012). The research population investigated in this study were nurses who have worked with psychiatric patients at the district hospital who have been employed there for at least six months.

Purposive sampling was used to sample the study participants. In purposive sampling, participants are selected because of some defining characteristics that make them the appropriate people to give information about the study or data needed for the study (Maree, 2007). Initially, the researcher, with the assistance of the nursing service manager, selected professional nurses working the day shift in the medical ward since psychiatric patients are admitted to these wards. They were approached individually by the researcher after the permission was granted by the hospital manager. The researcher explained the purpose of the research to the professional nurses and asked their willingness to take part in the study. Most participants agreed to participate in the study. Unfortunately, due to rumours that were going around regarding public servants pension funds, two of the selected professional nurses resigned before the commencement of the study and were no longer interested in taking part in the study. Two other professional nurses decided later that they were no longer interested in taking part in the study. Four of the eight originally targeted professional nurses remained.

At a later stage, the researcher decided to include other categories of nurses, that is, enrolled nurses and auxiliary nurses, who have worked with psychiatric patients because there were few professional nurses working at the district hospital, consequently, the sample size was going to be very small. The other reason was that other categories of nurses also care for psychiatric patients in the district hospital medical wards. So, four professional nurses, one enrolled nurse and three auxiliary nurses were selected for the study.

The researcher approached the nurses individually, explained the purpose of the study and asked their willingness to take part in the study. All the participants agreed to take part in the study. Information sheets (see Annexure A) regarding the study were given to participants and they were also requested to sign consent forms (see Annexure B) after reading the information sheets.

3.5 Description of participants

Eight nurses working in the rural district hospital were interviewed. Four out of eight participants were professional nurses, three of which were trained in psychiatric nursing and one trained in general nursing and midwifery; one enrolled nurse and three assistant nurses. All participants were females with their ages ranging from 26 to 60 years. Their experiences in working with psychiatric patients ranged from 1 to 6 years.

Table 3. 1: Summary of characteristics of participants

Participant	Age	Gender	Designation and Qualification	Years of service in the rural district hospital
P1	50 years	Female	Professional nurse (General nursing, Community nursing, Psychiatric	4 years

			nursing) and Midwifery	
P2	60 years	Female	Professional nurse (General Nursing and Midwifery)	2 years
P3	50 years	Female	Professional nurse (General nursing, Community nursing, Psychiatric nursing) and Midwifery	5 years
P4	26 years	Female	Professional nurse (General nursing, Community nursing, Psychiatric nursing) and Midwifery	1 year
P5	34 years	Female	Enrolled Nurse	5 years
P6	35 years	Female	Assistant Nurse	6 years
P7	34 years	Female	Assistant Nurse	5 years
P8	29 years	Female	Assistant Nurse	2 years

3.6 Data collection

The researcher used in-depth interviews as a data collection method. Eight in-depth interviews were conducted.

3.6.1 In-depth interviews

An in-depth interview is a qualitative research technique that mainly involves conducting intensive individual interviews with a small number of respondents to explore their perspectives on a particular idea, programme, or situation (Boyce *et al*, 2006). Patton *et al* (2002) contend that this method is used on topics for which little is known and where it is important to gain an in-depth understanding. The exploration is enhanced by the use of open-ended questions with probing and use of prompts (Legard *et al*, 2003). Interviews can take place in a group setting or through telephone but are commonly conducted on one-on-one and face-to-face basis (Robson, 2011). The researcher conducted one-on-one and face-to-face interviews with participants due to the small number of nurses working in the district hospital.

In-depth interviews were conducted between February 2016 and March 2016. Interviews took place in the researcher's office, away from the hospital to provide a neutral venue for nurses to be able to share their experiences freely. The interviews were conducted in English, since the participants are nurses and it is a medium of instruction at the workplace. The interview lasted for approximately 45 minutes. All interviews were recorded on a tape-recorder, with the permission of the participants and transcribed verbatim. The researcher used open-ended questions to get information from the study participants. He also used his interviewing skills as an advanced psychiatric nurse to encourage participants to talk about their experiences in caring for psychiatric patients. The participants were encouraged to elaborate on their responses; this allowed flexibility in gathering information from them (Burns *et al*, 2009). An interview guide (see Annexure C) was formulated prior to the interview in order to ensure uniformity during the data collection process. Body language such as, facial expressions and the use of gestures were taken note of and recorded in a diary.

3.7 Data analysis

Qualitative analysis is mainly an inductive way of eliciting meaning from the text, then arranging the data into categories according to these meanings and identifying patterns which show the interrelatedness among these themes (Pope *et al*, 2000). There are different ways of analysing data. For this research, Thematic Coding Analysis was used. The researcher

familiarised himself with the data during transcription. After listening to and transcribing the data, the researcher coded it, which involved categorising the data into segments. After coding, the researcher clustered similar codes together, clustered codes into emerging themes and analysed the patterns and links between themes. As proposed by Robson (2011), the data analysis was concurrent with data collection and guided subsequent interviews.

3.8 Rigour

Long *et al* (2000) refer to rigour in qualitative study as the worthiness of the study, with worthiness referring to the soundness of its methods, the accuracy of its findings and the integrity of assumptions made or conclusions reached. The criteria for judging the qualitative research should fit the realities of qualitative research such as trustworthiness or credibility (Davies and Dodd, 2002). From the qualitative research perspective, rigour is achieved “by eliminating bias and increasing the researcher’s truthfulness of a proposition about some social phenomenon” (Golafshani, 2003: 604). To achieve rigour, the study made use of triangulation of data sources by interviewing different nurses. Triangulation has been described as “...a validity procedure where researchers search for convergence among multiple and different sources of information to form themes or categories in a study” (Creswell *et al*, 2000:126). Triangulation of data sources was also supplemented with triangulation of literature, which provided general background knowledge about the phenomenon being studied.

The researcher also summarised each interview and verified with the respondents that his understanding and interpretations of their perceptions and opinions was accurate, applying what Creswell *et al* (2000) refer to as member checking or respondent validation which they describe as consisting of taking data and interpretations back to the participants in the study so that they can confirm the credibility of the information and narrative account.

Researcher reflexivity is important in qualitative studies where the researcher is close to the study and it was also used by the researcher to clearly state his expectations with regard to caring for psychiatric patients in a district hospital. Creswell *et al* (2000) describe reflexivity in qualitative research as a process whereby the researcher reports on personal beliefs, values, and factors that may shape their biases. The researcher is a district mental health coordinator. One of his responsibilities is to ensure that psychiatric patients are cared for in the district hospital. Therefore, due to this expectation, there is the potential for him to influence the findings of the study. Hence, the researcher applied bracketing, that is, the researcher identified and set aside any preconceived beliefs, opinions and expectations that he might have about the

phenomenon (Brink *et al*, 2011). In addition, the researcher explained the purpose of the study and the benefits of responding honestly to the research interview to minimize the potential of participants giving him what he wanted to hear. Also, researcher kept a diary and recorded detailed field notes including thoughts and feelings about the research process.

Furthermore, the researcher has been assigned a supervisor, who reviewed the researcher's work and provided support in the form of constant feedback. This strategy is known as peer review and debriefing and Creswell *et al* (2000:129) define it as, "*The review of data and the research process by someone who is familiar with the research or the phenomenon being explored*".

3.9 Ethics statement

Ethical clearance for the study was obtained from the University of the Western Cape Senate Research Committee and from the Department of Health, both Provincial and District Health Authorities as well as from the District Hospital. To ensure anonymity, participants' names are not included in the collected data; (1) A code is placed on collected data; (2) Through the use of an identification key, the researcher is able to link data to participants' identity (3) Only the researcher has access to the identification key.

To ensure confidentiality, recorded data was locked away in filing cabinets and storage areas, the researcher only used identification codes on data forms and also used password-protected computer files.

It was not anticipated that the study will be of any harm to the participants but all human interactions and talking about self or others carry some amount of risks. No participant reported any discomfort, psychological or otherwise during the process of their participation in this study, nevertheless measures were put in place for any eventualities for appropriate referral to a suitable health professional for further assistance or intervention. This research was not designed to help participants personally, but the results helped the investigator learn more about the nurses' perception of psychiatric patients in a rural district hospital. It is hoped that other people might benefit from this study through improved understanding of caring for psychiatric patients in a rural district hospital.

Participants were informed that this research is completely voluntary. They could choose not to take part at all. If they decided to participate in this research, they could stop participating at any time. If they decided not to participate in this study or if they stopped participating at

any time, they would not be penalised or lose any benefits to which they would otherwise qualify.



CHAPTER 4

RESEARCH RESULTS

4.1 Introduction

This chapter presents the findings of nurses' perceptions in caring for psychiatric patients in a rural district hospital. The participants shared their perceptions in this regard. They also made proposals on how the rural district hospital can improve in order to enhance caring for psychiatric patients.

4.2 Emerged Themes

Four themes and seven sub-themes emerged from the data analysis. The themes were patients' behaviours with two sub-themes; ability to work with psychiatric patients with two sub-themes; infrastructural factors with three sub-themes and feelings experienced by nurses.

4.2.1 Patients' behaviour

Patients' behaviour was described by participants according to what they observed and experienced. These behaviours were categorised into those that were described as making participants comfortable and those that make participants uncomfortable. Mostly, the presence of a mentally ill patient in a unit is perceived by nurses as a hindrance, which interferes with their duties. Nurses were not happy with the presence of a mentally ill patient in their wards. They anticipated serious problems which might disturb their normal day to day routine. It must be noted that those patients that nurses consider to be calm and cooperative and are comfortable to care for, are not often admitted to the district hospital.

4.2.1.1 Uncomfortable behaviour

Participants experienced violence, aggression, wandering of patients and strange behaviour. They indicated that psychiatric patients who displayed such behaviours are difficult to work with and that makes them uncomfortable. The findings were not different from findings from previous studies (Lethoba *et al*, 2006; Mavundla, 2000 and Breeze *et al*, 1998).

Roaming behaviour

The first attribute perceived by nurses in general hospital units is the roaming behaviour. This usually results in many patients getting lost. Nurses also revealed that it was very difficult for them to observe these patients. A roaming patient makes it very difficult for nurses to take care of other patients who demand constant attention, such as patients with medical and surgical related problems. Following or searching for a patient who is roaming around the hospital premises can take up a lot of the nurses' time, which they could have used in other productive ward activities. The concern was best espoused by the quote from a participant as follows:

“Every time I should go and look for a patient because you will get busy and you have to...when you come back again the patient is gone, you must go and look for the patient and as I said that most of our psychiatric patients are absconding, they just abscond and go around to Hanover [a small town 60 kilometres from the district hospital]” (P1, professional nurse).

Unruliness

While roaming around in the hospital, some patients become unruly and make noise which disturbs the quiet atmosphere required in a ward. This was perceived by nurses as a major problem to themselves and to other patients. In a general hospital, there are many patients suffering from illnesses and injuries resulting in severe pain, according to nurses, these patients' rest should not be disturbed. Some of the nurses, mentioned the following statements:

“They disturb other patients because they don't sleep, some of them you give them all those medications and still does not do anything to them so they go on disturbing other patients wanting tobacco..... other patients now can't sleep at the end of the day, you know so when is the patient going to sleep because you need rest to heal really, uyabona (you see)” (P5, enrolled nurse).

Violent behaviour

Apart from being unruly and noisy in general hospital wards, some of these patients are very aggressive and violent. Nurses revealed that some mentally ill patients are verbally abusive and that they threaten the nurses and other patients in the ward. One of the nurses, recounted the following experience of physical violence:

A white patient who was also a psych patient and was a bit aggressive..... most of the time when you are coming to her and give her medication, she refused to drink the medication and she threatened you and she wants to go home..... I was bringing the water to the patient then he kicked the glass so such, I told myself I will never go to that patient (P6, assistant nurse).

Strange behaviour

Other patients display strange behaviour that is unfamiliar to the nurses, examples of this include picking up phones and writing on the walls in the ward and also shouting at nurses for no apparent reason. This surprises other patients and nurses. One of the participants mentioned that:

“Some of them they are doing funny things like pick up our phones, you see, and writing the walls, doing all those funny things in the ward” (P8, assistant nurse).

4.2.1.2 Comfortable behaviour

Very few positive statements emerged from nurses with regard to the manner in which they experienced mentally ill patients in a ward or unit. The positive nature of nurses' responses was based on the perception of their self-adequacy with regard to possessing appropriate knowledge and skills to assist mentally ill people. It was noted that when psychiatric patients exhibit behaviour that is calm, cooperative and non-violent, though very few of them do, nurses find it comfortable to care for them. It appears that nurses become comfortable to care for such patients because they can interact comprehensibly with them and the behaviour of those patients does not challenge the nurses' skills and competence. It also appears that the patients that are said to be calm, cooperative and non-violent are those that are diagnosed with conditions such as depression or anxiety disorders. One of the participants mentioned that:

“There are psych patients that are more calm that are not aggressive, like last week we had a psych patient, that patient was very calm so we were comfortable to work with her because she was not aggressive or anything, she was very calm, we used to talk with her, and joke with her, we sit with her so there was no problem with me” (P6, assistant nurse).

4.2.2 Ability to work with psychiatric patients

Ability to work with psychiatric patients is another theme which is further categorised into education, training and support.

4.2.2.1 Education and training

The nurses' lack of knowledge and skills required to nurse mentally ill patients they come across in their units evoked a negative self-perception. They were of the opinion that they are inadequately equipped for nursing such people effectively. Most nurses acknowledged their

ignorance of mental illness. At times they speculate on the cause or origins of mental illness in a patient they come across as illustrated by the following quote from one of the participants:

“I am not a trained psychiatric nurse, I have just got basic and maternity. For patients who are violent then we do not know how to manage them then we use our own discretion. We didn't get even the courses to work with psych patient so we do not know actually how to handle a psych patient” (P2, professional nurse).

The nurses highlighted that knowledge and therapeutic skills were appropriate for nursing mentally ill people in their units and that these aspects would increase self-perception within their internal environment. They were of the opinion that nurses needed to be skilled and knowledgeable to understand the patient. They believed that this would improve the interaction of the nurse with their external environment as captured in the quote below:

“We are not trained in the wards but in our courses we are doing the basics, not the in-depth but the basics. I think if we have something like a workshop every month or having lessons about psychiatric patient every month, it can help us” (P6, professional nurse).

4.2.2.2 Support

In a medical ward because of fear of violence or the loss of a patient, nurses either approach the security guards or the managers for help, usually in vain. As a result, they feel unsupported in such cases. Personal safety concerns were reinforced with the perceived lack of support as stated by one of the participants in the quote below:

“There is no support because even if you phone your manager he will tell you to go ahead with the treatment that your doctor has prescribed so there's no real support..... the securities say is not their work to look after psychiatric patients”(P1, professional nurse).

Some participants also cited the lack of support from mental health specialist teams in the absence of managers for support. They reported that the focus of the specialist team may only be in primary health care facilities (clinics) other than the hospital as mostly they are not informed when there is a visit by the specialist team. One of the participants mentioned that:

“Even the specialist team mostly went to the clinics and when they do come we don't know, we are not informed by memo that the doctor is coming” (P2, professional nurse).

In the absence of both managers and specialist team, a concern was raised that there is nothing guiding nurses when they admit psychiatric patients in their wards and they find themselves not knowing what to do especially with psychiatric patients that display behaviours that make them uncomfortable. The participants believed that having something to use as a guide in times

of need will make their work easy and possibly reduce the stress of not knowing what to do when a psychiatric patient with conflict behaviours is admitted in the ward as illustrated in the quote below by one of the participants.

You can't work without protocols and policies guiding people what to do, even what is this thing called.....procedure manuals, you will know now when a psychiatric patient comes in this is what you need to do, those are not in place, all of this are not in place you see, so we need to have those and it will make our work easier (P1, professional nurse).

4.2.3 Infrastructure factors

Apart from the behaviour of the patients, the researcher also discovered that, within the internal environment of nurses, they were very concerned about the unit or ward in which they nurse mentally ill people. They also mentioned staff shortages and overcrowding as additional problems that make it very difficult for them to render adequate nursing care to mentally ill people.

4.2.3.1 Structural design

Most of the participants were concerned about the structural design of the district hospital. They believed that the district hospital was not designed to provide care for psychiatric patients and therefore is not suitable for psychiatric patients. The expressed concerns suggested that a place or area housing psychiatric patients with conflict behaviours should meet certain infrastructural [environmental] requirements that take patient safety into consideration as captured in the following quote:

“It (hospital) is not for psychiatric patients because usually, we put them here, you see the door, the gate then it's a ward, they are lying there but it's easy for them to go out. It's not suitable for psychiatric patients. This hospital is not safe for the psychiatric patient, most of the psychiatric patients we admitted in this hospital they abscond mostly and we don't have the burglars so this hospital is unsafe” (P8, assistant nurse).

4.2.3.2 Staff shortage

Among other things, a shortage of staff was cited by nurses in relation to bustling wards or units that cater for patients with serious medical or surgical disorders. A poor nurse–patient ratio resulted in challenges as it made it impossible for nurses to cope with the workload and at the same time unable to attend to the needs of other patients. It became evident that nurses were not coping and were unable to develop a relationship with mentally ill people. The only

thing that they could do was to administer medication to patients which according to them is not the only thing that psychiatric patients need. One of the participants stated that:

“We have a shortage of staff so we don’t really do as we are supposed to do to with the psych patient. There are no activities and stuff that we supposed to do with psych patients. We only giving them medication and we don’t know how these patients feel like, and how we can actually interact with them at some point” (P4, professional nurse).

4.2.3.3 Overcrowding

Nurses also complained of insufficient care rendered to mentally ill people because of patients’ overcrowding in the units. This problem was perceived as a serious threat to the recovery of other patients when viewed in the perspective of the necessity for serenity. The quote below captures the articulation from one of the participants.

“In this hospital, we mix everyone, whether it’s medical or surgical or psychiatric as long as it’s a male or female, they mix everyone. We don’t have space for the psychiatric patients” (P4, professional nurse).

4.2.4 Feeling experienced by nurses

While the environment posed a serious problem to the recovery of mentally ill people in the district hospitals’ medical wards, nurses' feelings were another issue. Before nurses could help a mentally ill patient they experienced feelings that made it very difficult for them even to be near the patient. They were mostly concerned about their own safety. As a result, they kept asking themselves a number of questions: ‘Is it safe to come closer to him/her?’ Nurses expressed a feeling of fear with regard to the care of psychiatric patients in a medical ward of a district hospital.

Fear

Almost all the participants reported a fear of psychiatric patients in their wards. They experienced fear because of a lack of understanding of the condition of the patient. As a result, they exaggerated what they thought the patient would do to them as captured in the quote below:

“Most of the time we are afraid of psychiatric patients. It might be that sometimes I think the patient is aggressive even if he is not, just the way he is looking at me or she is looking at me and then I think maybe this patient can strangle me or attack me and the patient sometimes is not even....[aggressive]” (P6, assistant nurse).

4.3 Solutions proposed by participants

Participants had different opinions about the admission of psychiatric patients in medical wards. There were three strong views on what could be done to resolve the problem. They suggested training for them to be able to care for psychiatric patients in their wards. Secondly, they suggested that patients should be separated so that psychiatric patients can have a fit-for-purpose infrastructure. Lastly, they suggested that there should be additional nursing staff in the unit to augment the current compliment.

4.3.1 Training

Some participants proposed a training programme or workshop where staff are taught about caring for psychiatric patients. Such training should be structured according to participants, and should not be once-off, as it should be done regularly. One of the participants mentioned that:

“...a programme where they educate staff first about the psychiatric patient and how to go about as to nursing them and maybe that can improve everything. I think if we have something like workshop or training on how to handle a psych patient, every month we having lessons about psychiatric patients it can help” (P4, professional nurse).

4.3.2 Designated wards

Some participants proposed separate wards where medical patients will be on their own with their own staff and that psychiatric patients should be cared for by staff trained in psychiatry and minimise mixing of patients. They further suggested that for psychiatric patients the ward must be secured with burglar doors or safety gates. It was well captured with the following quote from a participant:

“So if maybe they can try to get a place for them like psychiatric patients and minimise this mixing of the patients that can also help somewhere, create a room with burglar bars where a patient can be there if that patient is violent. Like in the other hospital whereby psychiatric patients have their own sort of a ward and then so that they can have their own staff” (P5, enrolled nurse).

4.3.3 Staffing

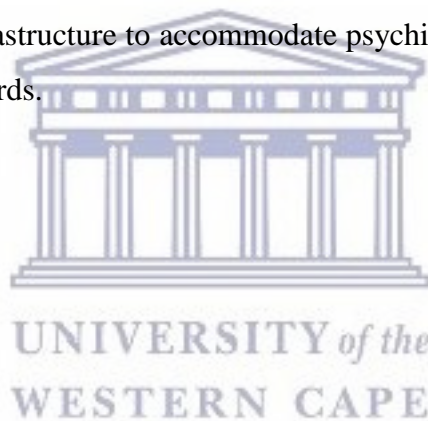
As noted by participants, shortage of staff is of concern. They proposed that additional staff members should be allocated accordingly, meaning that there will be staff members that will

be allocated to care for psychiatric patients whilst others care for other patients in the ward. According to the study participants, that will enhance caring for psychiatric patients in the district hospital. One of the participants mentioned that:

“If we are having a lot of staff, some will be allocated to psychiatric patients, you see, they will look after those patients but if there’s no staff, we need to do everything because we are having patients who are going to and coming from the theatre so it’s very difficult” (P7, assistant nurse).

4.4 Conclusion

The four major themes and seven sub-themes from the nurses working with psychiatric patients were presented. The results elucidate that nurses feel inadequately trained to nurse psychiatric patients. They view them as being aggressive and this evokes fear amongst nurses. Proposals were also made to enhance caring for a psychiatric patient in a rural district hospital. They included regular training as some of the nurses were never trained in psychiatry. There was also a proposal to change infrastructure to accommodate psychiatric patients and refrain from mixing patients in medical wards.



CHAPTER 5

DISCUSSION

5.1 Introduction

This chapter discusses the major findings of the study as they relate to its purpose of exploring the perceptions of nurses in caring for psychiatric patients in a rural district hospital. The findings of this study are consistent with what is already known in the literature as discussed in chapter 2. These findings demonstrate the predicament of nurses working in a rural district hospital which is not designed to provide for psychiatric patients. Furthermore, the findings also bring to the surface the challenges faced by nurses when they are not equipped with skills to care for psychiatric patients.

5.2 DISCUSSION

There are four themes that emerged from the current study: Patient behaviour, the ability to work with the psychiatric patient, infrastructural factors and feelings experienced by nurses.

5.2.1 Patient behaviour

The first characteristic perceived by nurses in general hospital units is the roaming behaviour, which usually results in many patients getting lost. In this study, it was revealed that it was very stressful for nurses to look after these patients and other patients because a roaming patient makes it very difficult for them to take care of other patients who demand constant attention, examples being patients with medical and surgical related problems. Following or searching for a patient who is roaming around the hospital premises can take up a significant amount of the nurses' time which they could have used in other productive ward activities. Cipriani *et al* (2014) refer to roaming as aimless or disoriented ambulation throughout a facility, often with observable patterns such as lapping, pacing, or random ambulation, associated with getting lost unless accompanied. This definition supports the findings of this study in that patients were leaving the ward randomly and walking around aimlessly around the district hospital premises and eventually getting lost. As a result, nurses felt that a roaming patient made it very difficult for them to render nursing care (Lethoba *et al*, 2006).

As patients were roaming, they became unruly and made noise which disturbed the quiet atmosphere required in a ward. This was perceived by nurses as a major problem to themselves and to other patients, especially those with medical and surgical problems who need a quiet place for healing. In this study, it was revealed that psychiatric patients disturb other patients when they are asleep, they wake them up to ask for tobacco. Similar findings were noted by Breeze *et al* (1998), who noted that noise causes a disturbance on the quiet environment of the hospital which added to the problems nurses have to be faced with.

The other characteristic was aggression and violence by psychiatric patients which has long been recognised as a significant and increasing problem in psychiatric settings (Mulvey, 1994). As indicated earlier, Duxbury (1999) attributes patients' aggressive outbursts to internal factors such as frustration and fear. In this study, it was revealed that some mentally ill patients were very aggressive and violent and that they threatened the nurses. The aggressive and violent behaviour could be as a result of fear or frustration. However, of importance to note is that the findings of the current study are consistent with the previous study of Mavundla (2000), where nurses revealed that psychiatric patients threatened them, irrespective of what may have led to the behaviour.

As a result of this aggressive behaviour by psychiatric patients, nurses not only felt threatened but they also experienced fear. They experienced fear because of a lack of understanding of the condition of the patient or probably due to previous experience of violence by psychiatric patients. Consequently, they anticipated and exaggerated what they thought the patient would do to them. In the current study, nurses expressed a feeling of fear with regard to the care of the psychiatric patient in a medical ward of a district hospital. This emotion fear, which is emotionally taxing, according to Jackson *et al* (2014) was even triggered by the look the patient gave to staff members. These findings are consistent with the findings by Terkelsen *et al* (2016) where it was revealed that when the professionals were expecting the arrival of a patient they knew had been aggressive before, preparations were made for physical restraint, this was done in anticipation.

As a result of this aggressive behaviour, nurses in the current study suggested that psychiatric patients must be separated from other patients. This notion is consistent with findings by Gule (2013) where participants proposed that psychiatric patients be sequestered from the general wards as they are a risk to other patients, families, as well as the nurses.

Contrary to negative experiences, very few positive statements emerged from nurses with regard to the manner in which they perceive mentally ill patients in a ward or unit. Apart from the perception of self-adequacy with regard to possessing appropriate knowledge and skills to assist mentally ill people, the positive nature of nurses' responses was based on the sense of duty to care for the mentally ill as they believed, according to the findings of the current study, that psychiatric patients are like any other patient that must be treated with respect and dignity. These findings are supported by Mavundla *et al* (1997) who found that only 3% of nurses had a positive attitude towards mentally ill people in a study conducted in a general hospital in a sample of 100 nurses. Interestingly, similar results were found by Reed *et al's* (2005) study that, a small number of participants revealed very positive attitudes to caring for people with mental illness. They attributed this to their life experience and the recognition of mental health being an integral part of holistic nursing care.

5.2.2 Ability to work with psychiatric patients

Ability to work with psychiatric patients is another theme which is further categorised into education, training and support

5.2.2.1 Education and training

Nurses' lack of knowledge and skills required to nurse mentally ill patients they come across in their units evoked a negative self-perception. They were of the opinion that they are inadequately equipped for nursing such people effectively. Most nurses acknowledged their ignorance of mental illness. At times they speculate on the cause or origins of mental illness in a patient they come across. These findings are supported by a study from Sharrock *et al* (2005) which revealed that, there is evidence that general nurses perceive themselves as lacking knowledge in assessment and management of psychiatric patients and that it is difficult for them to render care that will meet the patients' needs.

5.2.2.2 Support

Fear of violence or the loss of a patient leads nurses to either approach the security guards or the managers for help, usually in vain. As a result, they feel neglected and uncared for and this might probably increase the level of stress and leaves nurses feeling overwhelmed. In this study, nurses reported that they are not supported by their managers and specialist team. Furthermore, non-availability of protocols and guidelines to support nurses in caring for

psychiatric patients that display behaviour they consider uncomfortable in the absence of managers and specialist team made the situation frustrating. The findings are consistent with the findings of a study by Bimenyimana *et al* (2009) where it was revealed that the participants expressed feelings of isolation and dissatisfaction concerning the support they expect but are not receiving from the management and the multidisciplinary team. Reed *et al* (2005) concur that nurses need more practical and emotional support in caring for people with mental health problems due to the stressful and complex nature of their work. The authors argue that the lack of knowledgeable support and delay in access increased the perception of danger.

5.2.3 Infrastructural factors

Most of the participants were concerned about the structural design of the district hospital. They believed that the district hospital was not designed to provide care for psychiatric patients and therefore was not suitable for psychiatric patients. Similar articulations were verbalised by participants in a study by Thupayagale-Tshweneagae and Ganga-Limando (2014) as captured in the following quote: *“I do not understand why psychiatric patients must be admitted to a general hospital. The general hospital must admit medical patients, not psychiatric patients”* (Thupayagale-Tshweneagae *et al*, 2014:981). The study findings by King *et al* (2001) also shares the same sentiments, it revealed that health professionals in a rural regional study were of the opinion that the hospital environment created many functional difficulties in caring for people with mental health problems.

Shortage of staff was an area of concern cited by nurses in relation to bustling wards or units that cater for patients with serious medical or surgical disorders. They felt that a poor nurse–patient ratio resulted in challenges as it made it impossible for them to cope with the workload and at the same time unable to attend to the needs of other patients. Shortage of staff has been cited quite extensively as a concern for health care in general but more particular in rural district hospitals, especially where general medical wards have to make provision for psychiatric services. Mavundla (2000) noted that a shortage of staff became evident through field observations and verbal statements made by nurses. It became very difficult for nurses to develop a relationship with mentally ill people. They could not even counsel such patients because most of their time was spent in ensuring that their routine work was completed. Nurses also complained of inadequate care rendered to mentally ill people because of patients’ overcrowding in these units. This problem was perceived as a serious threat to the recovery of other patients when viewed in the context of the necessity for tranquillity. However, Lethoba

et al (2006) concede that in-service training could overcome the problems of staff shortages and overcrowding.

5.3 Conclusion

The management of psychiatric patients in district hospital poses challenges for nurses. The safety and psychiatric nursing competence concerns expressed by nurses should be addressed. It is evident that nurses lack the education to deal with psychiatric patients. Continuing professional development education should include content related to psychiatric nursing care, especially the management of violent behaviour associated with mental illnesses. Hospital management should establish defined physical spaces in the district hospital for psychiatric patients in order to decrease extraneous stimulation and afford a degree of privacy. Other measures addressing issues such as staffing, lack of support and guidelines in dealing with aggressive behaviour should also be considered.



CHAPTER 6

CONCLUSIONS LIMITATIONS AND RECOMMENDATIONS

6.1 Introduction

The preceding chapter discussed the major findings of the study. The chapter also situated the study findings to the available literature. This chapter presents the summary of the study, its limitations as well as the recommendations.

6.2 Conclusions

This study explored the perceptions of nurses working in a rural district hospital on caring for psychiatric patients. By examining this phenomenon, the researcher attempted to provide insight into the nurses' concerns and experiences. Current literature was used to understand the experiences of nurses caring for psychiatric patients.

The study found that patients' behaviour, especially the patients' uncomfortable behaviour, the lack of skills and knowledge, infrastructural factors and human resources are concerns for nurses caring for psychiatric patients in a rural district hospital. Psychiatric patients who displayed behaviour that is deemed uncomfortable were difficult to work with and that made nurses uncomfortable. However, not all behaviour displayed by psychiatric patients was deemed uncomfortable, some patients were said to be cooperative, and were deemed comfortable to work with.

Secondly, lack of knowledge and skills required to care for mentally ill patients evoked a negative self-perception for the nurses. They regarded themselves as being inadequately equipped for caring for psychiatric patients effectively and they argued that they are not supported by their managers and the mental health specialist team.

Thirdly, nurses were also concerned about the unit or ward in which they nurse mentally ill people. They believed that the district hospital was not designed to provide care for psychiatric patients and therefore, not suitable for psychiatric patients.

Lastly, nurses expressed a feeling of fear with regard to caring for a psychiatric patient in a medical ward of a district hospital. They were mostly concerned about their own safety.

Nurses had different opinions about the admission of psychiatric patients in medical wards. There were three strong opinions on what could be done to resolve the problem. They suggested training for them to be able to care for psychiatric patients in their wards. Secondly, they suggested that patients should be separated so that psychiatric patients can have a fit-for-purpose infrastructure. They also suggested that there should be additional nursing staff in the unit to augment the current compliment.

The findings of the study support that which is already known in the literature. The current study recommends strategies for improvement of care to psychiatric nurses through education, practice and research. These recommendations are given at the end of this chapter.

The findings of this study have the potential to make a significant contribution to caring for psychiatric patients in rural district hospitals in the country and beyond.

6.3 Study limitations

The sample size did not reach data saturation as envisaged with qualitative research due to the nature of the mini-thesis, which is a small study which is not as comprehensive as a full thesis, but given the literature supporting the study, it provides a significant basis on which to make recommendations. In addition, the study findings should not be generalised since the aim was to understand the nurses' perceptions regarding caring for psychiatric patients in a rural district hospital in Northern Cape, South Africa.

As the District Mental Health Coordinator, the researcher has the responsibility to ensure that psychiatric patients are cared for in the district hospital. Therefore, due to this expectation, there was a risk of him being biased and influencing the findings of the study. To minimise this effect, the researcher kept a diary to record his expectations. He also implemented processes described in the section on rigour to limit any bias. An additional factor is that the researcher, who is known in the district, conducted the interviews which may have led participants giving the researcher what he wanted to hear. This might have reduced the authenticity of what the nurses were sharing about their experiences and perceptions.

6.4 Recommendations

The recommendations for this study are for future research, policy, education and practice. Some of these recommendations have been made in previous studies. The current study re-emphasise the importance of those recommendations.

6.4.1 Recommendation for future research

This study may serve as a base for future studies. It would be beneficial if similar studies could be done in other institutions, particularly on the impact of fit-for-purpose structural design in rural district hospitals to enable the staff to care for psychiatric patients and in order to give reliable empirical evidence that can inform policies.

6.4.2 Recommendation for policy

Recommendations are that in future, before the implementation of any policy, the proper situational analysis must be done to ensure that there are enough nurses who are trained in psychiatry in medical wards. Additionally, the infrastructure of medical wards must be assessed to ensure that it is conducive to nurse psychiatric patients, other factors such as the availability of seclusion rooms for psychiatric patients who need to be secluded due to their behavioural problems, closed wards to limit patients' movements and a ward constructed with hard to break windows should be considered. Lastly, monitoring and evaluation of the implementation of national staffing norms, e.g., Workload Indicator Staffing Norms (WISN) in district hospital to address the issue of staff shortages, and also for staff retention the correct implementation of Occupation Specific Dispensation (OSD), particularly to the nurses working in dedicated psychiatric wards of district hospitals should also be upheld.

6.4.3 Recommendation for nursing education

Education institutions, particularly nursing colleges should provide psychiatric training so that all nurses, general nurses, enrolled nurses and assistant nurses know how to interact with psychiatric patients. The findings of the current study highlighted the need for the training of nurses. They need communication skills to deal with psychiatric patients. It is also recommended that continuous in-service training by the district hospital in collaboration with the nursing college, is done by showing videos used in training colleges, on issues such as,

management of aggressive psychiatric patients, allaying anxiety and improving knowledge and skills in nursing psychiatric patients.

6.4.4 Recommendation for practice

Psychiatric nursing is a specialised area. Allocation of nurses in the wards by nursing managers should always include psychiatric trained nurses. Violence by psychiatric patients is not only apportioned to those that are not trained, but also to the trained nurses who would probably assess aggressive behaviour and prevent it by calming the patients, which is referred to as “de-escalation”. Allocating psychiatric trained nurses will also promote the care given to psychiatric patients. They will be better situated to allay other nurses’ and other patients’ anxieties.



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ANNEXURE A



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

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E-mail: soph-comm@uwc.ac.za

INFORMATION SHEET

Project Title: An exploration of the perceptions of nurses in caring for psychiatric patients in a rural district hospital, Northern Cape, South Africa.

This is a research project being conducted by **T.M Matsoso for School of Public Health** at the **University of the Western Cape**. We are inviting you to participate in this research project because you are a suitable candidate for the project. The purpose of this research project is to explore perceptions of nurses working in a rural district hospital on caring for psychiatric patients. The researcher intends to make recommendations to the district management based on the findings of the study.

You will be asked to participate in an interview which will be recorded, and which should take about forty five minutes. The interview will take place in the old female ward. In the interview, you will be asked about your perceptions regarding caring for psychiatric patients in a rural district hospital.

To ensure your anonymity, your name will not be included in the collected data; (1) a code will be placed on collected data; (2) through the use of an identification key, the researcher will be able to link data to your identity; and (3) only the researcher will have access to the identification key.

To ensure your confidentiality, recorded data will be locked away in filing cabinets and storage areas, using identification codes only on data forms, and using password-protected computer files. 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.

This research is not designed to help you personally, but the results may help the investigator learn more about nurses' perception of psychiatric patients in a rural district hospital. We hope that, in the future, other people might benefit from this study through improved understanding of caring for psychiatric patients in a rural district hospital.

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 penalised or lose any benefits to which you otherwise qualify.

This research is being conducted by **T.M Matsoso for School of Public Health** at the University of the Western Cape. If you have any questions about the research study itself, please contact **T.M Matsoso** at: School of Public Health, University of Western Cape, +2776 758 5133, tsietsimatsoso@gmail.com.

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 Helen Schneider
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University of the Western Cape
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CONSENT FORM

Title of Research Project: An exploration of the perceptions of nurses in caring for psychiatric patients in a rural district hospital, Northern Cape, South Africa.

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 in 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.....

ANNEXURE C

INTERVIEW GUIDE

Explain the purpose of the interview. Assure the participant of confidentiality and anonymity. Also, remind the participant of the interview processes. Use the interview guide for guiding the process

1. PARTICIPANT INFORMATION

- a. Choose a pseudonym
- b. State your age, race, marital status
- c. What is your professional designation (professional nurse, enrolled nurse or auxiliary nurse)
- d. How long have you worked here?

2. EXPERIENCES IN CARING FOR PSYCHIATRIC PATIENTS

- a. Tell me about your experiences in caring for psychiatric patients (probe for the past and present experiences, how they feel or felt about caring for psychiatric patients, what their attitude is/was towards caring for psychiatric patients)
- b. What training or support have you had for this role?
- c. How does it feel to care for a psychiatric patient (look for challenges and strategies to overcome those challenges)
- d. Is there any support from the specialist psychiatric team (how often do they visit; when last did they visit; do they give in-service training; are there any protocols and guidelines that guide caring for psychiatric patients)?

3. VIEWS IN CARING FOR PSYCHIATRIC PATIENTS IN DISTRICT HOSPITAL

- a. What have you seen as your main role in the wards you are working in now?
- b. Given the above, how do you feel about caring for a psychiatric patient in a rural district hospital? (probe for their readiness in caring for psychiatric patient in terms of willingness and capacity)
- c. What are your views with psychiatric patients being cared for amongst other patients? (probe for fit-for-purpose structure, safety regarding patients and staff)

4. SUGGESTIONS IN IMPROVING CARE FOR PSYCHIATRIC PATIENTS

- a. How would you suggest that the hospital can improve in order to care for psychiatric patients?

b. What would be an ideal environment to care for psychiatric patients in district hospital?

5. ANY ADDITIONAL INFORMATION

- a. Is there any other information you think is relevant that we might have left out in your experience in caring for psychiatric patients?
- b. Do you have any questions for me?

Thank you for your time.



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21.01.2016

Northern Cape Provincial Health Research Ethics Committee

Kimberly

Attention: Dr Worku

Dear Sir

APPLICATION FOR PERMISSION TO CONDUCT RESEARCH IN A DISTRICT HOSPITAL

My name is Tsietsi Matsoso, employed at Pixley ka Seme District as District Mental Health Coordinator. I am also Master of Public Health (MPH) student enrolled at University of Western Cape (UWC).

This letter serves to apply for ethical approval to conduct a research project at one of the district hospital in the Northern Cape, which is the Central Karoo Hospital.

The research will explore *the psychiatric nurses' perceptions regarding the care of psychiatric patients admitted to a district hospital*. The project is being conducted under the supervision of Dr Ruth Stern, School of Public Health at the UWC.

The problem identified by the student is that, with the implementation of the MHCA, all health establishments including district hospitals are compelled to admit acute psychiatric patients for 72 hours for assessment and observation. Caring for psychiatric patients in medical wards of rural district hospital is of concern, as the hospital is not designed to make provision for these patients. Psychiatric patients, especially those diagnosed with severe mental illnesses, such as, schizophrenia, bipolar mood disorders may exhibit disruptive and aggressive behaviours which may be overwhelming to other patients not suffering from mental illness. Furthermore, a concern has been raised at this rural district hospital that given the nature of behaviours exhibited by psychiatric patients, it is often difficult to care for them because some of the nurses have no knowledge of how to handle disruptive, aggressive psychiatric patients as their training did not include psychiatry.

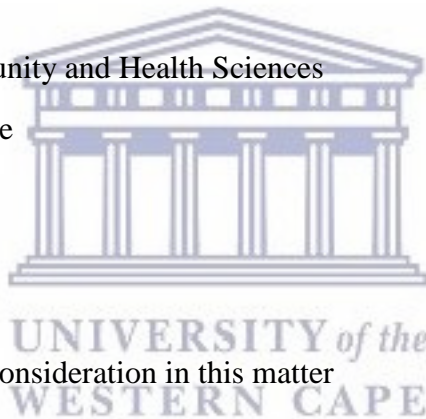
The aim of the study is to explore the perceptions of the nurses caring for psychiatric patients in a rural district hospital in order to gain a deeper understanding of their concerns and their experiences.

I have provided you with a copy of my research proposal which includes copies of the consent forms to be used in the research process, as well as a copy of the approval letter which I received from the SOPH Research Ethics Committee (Human).

Upon completion of the study, I undertake to provide the Department of Health with a bound copy of the full research report. If you require any further information, please do not hesitate to contact:

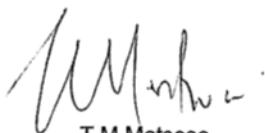
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Thank you for your time and consideration in this matter

Yours sincerely,



T.M Matsoso

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