

**THE EXPERIENCES OF PROFESSIONAL NURSES
WORKING IN DISTRICT HOSPITALS IN THE WESTERN CAPE
METROPOLE, WHERE 72-HOUR ASSESSMENTS ARE CONDUCTED**

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A mini-thesis submitted in fulfilment of the requirements for
the degree of Magister Curationis (Structured) in the School of Nursing,
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Date: August 2016

ABSTRACT

Background: The integration of mental health into primary health care meant that patients were admitted into a less restrictive environment. They received treatment for mental illness in their communities, therefore, averting unnecessary hospitalisation in psychiatric hospitals. However, given that patients with mental illnesses were admitted to district hospitals as involuntary mental health care users (MHCUs), this setting was purported to be fraught with challenges for both staff and patients.

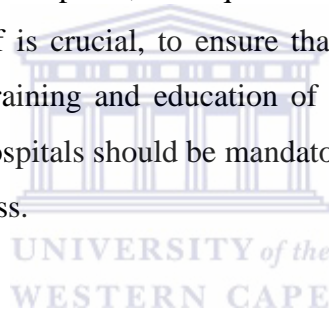
Aim and objectives: The aim of this study was to explore and describe the experiences of professional nurses, working at selected district hospitals in the Western Cape metropole, where 72-hour assessments of involuntary mental health care users are conducted. The objectives of this study were to determine how the 72-hour unit functioned in the general ward, the experiences of professional nurses regarding the integration of the 72-hour assessment units in the general ward and suggested improvements.

Methodology: A qualitative research approach, with a descriptive phenomenological design, was used to collect data through semi-structured interviews from eight (8) professional nurses, working in the two selected district hospitals in the Cape Town metropole area. Purposive sampling was employed to select the participants. Data were analysed using Tesch's method of qualitative data analysis. Four themes, namely, patient management process affected the functioning of the ward, patient management challenges in rendering patient care, burden of caring on the Self, and staff and patient support to create a therapeutic environment, emerged during data analysis, which encapsulated the nurse's experience of working in 72-hour assessment units in selected district hospitals.

Findings: The findings of this revealed that the district hospitals were ill prepared for the admission of involuntary mental health care users. There were challenges, in terms of resources, namely, infrastructure to create a therapeutic environment, knowledgeable and skilled staff to care for the MHCUs. The MHCUs were contained in the district hospitals for longer than was legislated, rather than receiving therapeutic interventions at psychiatric facilities. Needs were identified to improve the functioning of the 72-hour assessment units, which included education and training of personnel,

Discussion: The non-therapeutic environment had a negative impact on the staff working in the 72-hour assessment units. Nursing staff were burdened with caring for patients in an environment where they, as well as the MHCUs, were stigmatised due to the diagnosis of mental illness. However, the participants internalised their own experiences, as they prioritised the MHCUs well-being. The findings supported previous studies, which revealed that the objectives of the Mental Health Care Act (No. 17 of 2002), which supported the integration of mental health into primary health care, were not realised after more than a decade of implementation.

Recommendations: Given the limited scope of this thesis, replications of this study in other district hospitals are recommended, in order to ascertain whether the objectives of the MHCA (2002), regarding 72-hour assessments, have been realised. A therapeutic environment, which includes infrastructure and resources to ensure that MHCUs receive care, treatment and rehabilitation within the district hospitals, is required. The recruitment and retention of adequate, skilled permanent staff is crucial, to ensure that MHCUs receive care, treatment and rehabilitation. Finally, the training and education of *all* personnel (including security) working in the selected district hospitals should be mandatory, in order to address patient care and stigma related to mental illness.



KEY WORDS

District hospitals

Experiences

72-hour assessment,

Involuntary care,

Mental health care users,

Mental illness

Professional nurses,



LIST OF ABBREVIATIONS

MHCA (2002)	–	Mental Health Care Act 17 of 2002
MHCUs	–	Mental Health Care Users
WHO	–	World Health Organisation
WONCA	–	World Organization of Family Doctors



DECLARATION

I declare that *“The experiences of professional nurses working in District hospitals in the Western Cape metropole, where 72-hour assessments are conducted”* is my own work, that it has not been submitted before for any degree, or examination, at any other university, and that all the sources I have used, or quoted, have been indicated and acknowledged by complete references.

Name: Verna van Zyl

Date: August 2016

Signed:



ACKNOWLEDGEMENTS

First and foremost, I am grateful to God for providing me with good health and support. I praise and thank Him for the blessings and guidance during the difficult and good times.

Thanks to my children, Rigardt & Michelle and Hanni & Lise for your support and love. I thank God for blessing me with great children.

I want to extend my deepest gratitude to my supervisor, Dr Penelope Martin, for your encouragement, support and guidance. I admire your cool-headedness and expertise, which kept me inspired and helped me to persevere through this arduous journey. I appreciate your academic input and contributions. Thank you for being the beacon of light throughout this whole process.

To all my friends, family and colleagues, for kind gestures, encouragement, debriefing sessions and keeping me in your prayers. I truly appreciate your kindness, interest and care.

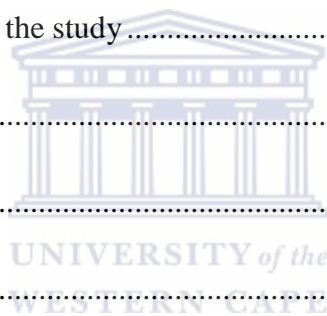
I want to thank the facilities for granting me permission to collect data.

Big thanks to the participants for granting me the opportunity to listen to your stories.

I am truly blessed.

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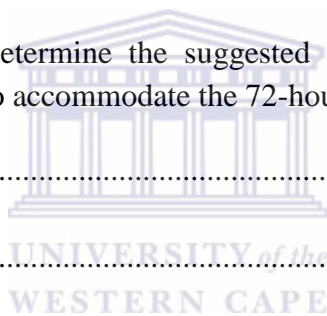


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CHAPTER ONE

ORIENTATION TO THE STUDY

1.1. Introduction

In South Africa, the Mental Health Care Act [MHCA] (No. 17 of 2002) makes provision for mentally ill persons, who are a danger to themselves or others, to be admitted for a 72-hour period of observation in district hospitals. This forms part of the integration of mental health care into primary care (Petersen & Lund, 2011), ensuring that patients receive treatment, in their communities, in the least restrictive environment, while avoiding unnecessary hospitalisation of patients in psychiatric hospitals (Burns, 2008). Generally, all categories of ill patients are admitted to district hospitals, where professional nurses, working in these hospitals, have to care for all patients – physically or mentally ill patients. Mental health care is a specialised field, as patients, known as Mental Health Care Users (MHCUs) may be aggressive and/or psychotic and the nurses at district hospitals may not necessarily receive the desired support to manage MHCUs, as their main focus of care is on general health. The environment at district hospitals, therefore, may not be conducive to the provision of 72-hour observations.

1.2. Background and rationale for the study

Mental illness is a global phenomenon and accounts for 12% of the burden of disease (World Health Organization [WHO] & World Organization of Family Doctors [Wonca], 2008). By 2020, mental illness will account for 15% of the disability-adjusted life-years lost to the illness (WHO, 2008). This implies that the population would have lost 15% of their years of healthy living. In addition, neuropsychiatric disorders are ranked third in their contribution to the overall burden of disease in South Africa (SA) after HIV/AIDS and other infectious diseases (South Africa, Department of Health, 2010). In addition, people with serious mental illness, such as schizophrenia, bipolar mood disorder and depression, may present with a co-morbid substance abuse disorder. A survey by South African Stress and Health [SASH] study estimated that the Western Cape had a higher lifetime prevalence of substance use, compared with other provinces, and predicted that 30% of adults in the Western Cape Province will develop a mental disorder in their life-time (Herman, Steyn, Seedat, Heeringa, Moomal, Williams & the SASH study, 2009). A study by Kalebka, Bruijns & Van Hoving (2012)

showed an upsurge of methamphetamine abuse, particularly in the Western Cape, which increased the burden of alcohol and substance related disorders, and as a result, the number of visits to emergency centres. Substance abuse affects the burden of mental illness, as substance abuse cause MHCUs to display deviant behaviours such as, aggression and violence (Luckhoff, Jordaan, Swart, Cloete, Koen & Niehaus, 2013).

According to the WHO & Wonca (2008), economic loss, suffering and disability are the results, when mental disorders are left untreated. However, only a small minority of people in need of mental health services receive treatment, despite a potentially high success rate, when treated. Integrating mental health care into primary care has been influential in closing the treatment gap. The WHO & Wonca (2008) allude to the following reasons for the integration:

- More than 60% of people, who are treated at primary health care centres globally, have a diagnosable mental illness; therefore integrating mental health services into primary health, is a viable option, to ensure that people receive the care they need;
- A link between mental illness and physical illness – holistic health care – could be offered to people. This means that people presenting with physical illnesses would also have their mental health needs met, while people with mental disorders would also have their physical needs met;
- An enormous treatment gap exists for people requiring care for mental illness, which will be closed with the delivery of primary mental health care;
- Access to mental health services, with patients receiving care in their communities, and the monitoring of mental illness, will lead to improved family cohesion;
- Reduced stigma and discrimination of people with mental illnesses will result; therefore, human rights will be enhanced;
- Affordable primary care for mental illness will ensue, as admissions to psychiatric hospitals will be avoided, and families will not have to spend money on accessing tertiary services, which are usually far from their homes; and
- Good health outcomes for people with mental illnesses, especially, when they are linked to secondary services in the community.

However, while there are advantages for integrating mental health into primary care, the WHO alludes to the pitfalls and the lessons learnt, globally, about the process of integration. Integration means more than simply locating persons with diverse specialities in one building, and expecting them to work together. Primary health care workers need training, supervision and support within a broader health care system, supported by readily available patient information. Resistance from staff, as well as their level of commitment to successful integration must be monitored. Plans and programmes must be specifically adapted to meet the needs of the community, and should be approved, as well as implemented. Consideration should be given to the fact that integration takes time, therefore, developments could transpire over years (WHO, 2014).

In South Africa, the MHCA (2002) was one such legislation that was enacted with the idea of expediting the integration of mental health care into primary care. In line with the provisions of the MHCA (2002), progress has been made towards decentralised, integrated, primary mental health care, with the introduction of the 72-hour observation and referral service for emergency MHCUs in designated general hospitals (Petersen, Lund, Bhana, Flisher & the Mental Health and Poverty Research Programme Consortium, 2011). Therefore, MHCUs, who present with psychiatric emergencies, such as aggression and or/psychosis, and require hospitalisation, are admitted to district hospitals for involuntary mental health care.

- **Involuntary mental healthcare**

Globally, involuntary care of mentally ill patients ensues when the person exhibits severe symptoms of mental illness, is an immediate danger to self and others, and lacks insight into his/her condition. The conditions, under which mental ill persons are detained, as well as the process, differ. In Australia, involuntary commitment of mentally ill patients transpires via the Emergency Department. Patients are assessed and have to wait, at times more than 48 hours, for acute inpatient beds to become available. These patients have to lie on trolleys in the emergency department during the assessment period (Browne *et al.*, 2010). In the United States of America (USA), emergency detention is governed by state laws, which differ from state to state. Involuntary admission of patients with mental illnesses is termed hold, pick-up, detention, provisional hospitalization, 72-hour emergency admission, involuntary examination, custody or emergency observation for emergency detention, or

hospitalisation depending on the state (Treatment Advocacy Centre, 2011). The law enforcement officer, or peace officer, plays an important role in the process of taking the person into custody, and transporting him/her to a designated mental health facility. The period of detention could vary from 48 hours to 72 hours; however, it could be extended to 14 days, legally (Treatment Advocacy Centre, 2011). The laws and practices of institutions and involuntary commitment have changed to fit the principles of freedom and liberty (Curtis, 2001).

Involuntary admission in the European Union countries is known as civil detention and involuntary placement (Salize & Dressing, 2004). In the United Kingdom, patients are described as being sectioned (Timms, 2013), which indicates the *section* in the Mental Health Care Act of 1986; however, the word *detained* is preferred. Norway prefers the term, *compulsory admissions* (Hanssen-Bauer *et al.*, 2011).

In South Africa, the admission process of involuntary MHCUs is described in the MHCA (2002), with regulations assisting the process. In order to facilitate the process of involuntary admission to a district hospital, the port of entry for a MHCU is the community healthcare clinics. An application for involuntary mental health care is submitted by an applicant, who may be a family member, or a health care worker. Subsequently, the MHCUs are assessed, medically and physically, and the necessary medical forms are completed by the relevant health care workers. After perusal of the documentation, the head of the health establishment, who is usually the facility manager, grants permission for the transfer and admission of the MHCU to the district hospital. The MHCA (2002) makes provision for two types of involuntary admissions, namely, inpatient and outpatient; however, the focus of this study is on inpatient involuntary care, also referred as the 72-hour admission and observation of involuntary MHCUs, conducted in the district hospitals.

- **72 hour admission and observations of MHCUs at district hospitals**

District hospitals are situated in the communities and are the initial access ports to hospital services. District hospitals should be within geographical ease for patients, with the expectation of providing a full package of care to patients, which includes mental health services and 24-hour access to services for physical health problems (WHO & Wonca, 2008). One of the services provided by district hospitals is the 72-

hour admission and observation of involuntary MHCUs, as legislated in the MHCA (2002). During the 72-hour period, it is established whether an involuntary MHCU should be provided with subsequent involuntary care, treatment and rehabilitation.

However, according to Burns (2008), the provision of 72-hour observations at most district hospitals are fraught with challenges, leading to sub-optimal levels of care. These include instances where the MHCUs are so heavily sedated that adequate review of their mental state is prevented; or agitated/psychotic MHCUs are inadequately sedated, making containment difficult and resulting in unsafe conditions for patients and staff. Medications, or doses thereof, administered to the MHCUs may be inappropriate with subsequent iatrogenic problems. MHCUs may be inadequately screened for underlying medical conditions, as the focus of care is on the mental illness, which, consequently, may lead to negligence in routine medical examinations and investigations. Additionally, there may be a failure to comply with the requirements of the MHCA (2002), in terms of the completion of the MHCA forms (Burns, 2008).

In a South African study by Janse van Rensburg (2010), concerns were raised about the inadequate infrastructure in district hospitals, where 72-hour assessments were conducted at primary care level. The author alluded to the inadequate and unsafe facilities, where 72-hour assessments were conducted in an inadequate, locked room adjacent to the casualty sections, or in an open, non-secure area (Janse van Rensburg, 2010). Petersen and Lund (2011) affirm that the human resources and infrastructure of the 72-hour emergency management and observation service in general hospitals need to be improved.

Given that the MHCA (2002) is more than a decade old, there appears to be major deficiencies in the delivery of involuntary mental health care in district hospitals, which prompted the researcher's interest in exploring the experiences of the professional nurses working in these settings. The researcher, who is a lecturer at a nursing college, had contact with professional nurses, who described the difficulties they experienced in caring for involuntary MHCUs, in the same ward as medical patients. They alluded to the non-therapeutic environment, in which patients were being cared for, as well as their own inadequacies, in terms of knowledge and skills

about caring for involuntarily admitted patients. They articulated their fear of being attacked, stigma related to caring for people with mental illness and the lack of support, as district hospitals were focused on the provision of general health. The researcher also discovered that there is a paucity of literature focusing on the 72-hour assessment units, as well as the experiences of professional nurses attached the practice in the Western Cape.

1.3. Problem statement

Professional nurses, working in the medical wards where 72-hour assessments are conducted, are expected to deliver nursing care to a diverse group of patients. They have to care, treat and conduct nursing interventions on medical patients, as well as MHCUs. Researchers Gule (2013) and Petska *et al.* (2012) affirm that the role of the psychiatric nurses in acute care is demanding and complex because of the diverse patient population. Literature (Janse van Rensburg, 2010; Petersen & Lund, 2011; Burns, 2010) and anecdotal evidence focuses on the inadequate human resources and infrastructure, as well as the difficulties that nurses experienced, while working with a diverse patient population. However, the experiences of professional nurses, working in district hospitals where 72-hour assessments on MHCUs are conducted, as part of the integration of mental healthcare into primary healthcare in the Western Cape metropole, is not known.

1.4. Aim of the research

The aim of this study is to explore and describe the experiences of professional nurses, working in the 72-hour assessment units, where involuntary MHCUs are admitted and observed, in selected district hospitals in the Western Cape.

1.5. Significance of the study

This study may provide baseline data on the experiences of professional nurses working in the general wards, at district hospitals, where 72-hour assessments of involuntary MHCUs are conducted. The results may influence policy and decision making around the effective integration of mental health care into primary health care.

1.6. Objectives of the study

- To determine the functioning of the 72-hour unit, in the district hospital;
- To explore and describe the experiences of professional nurses, regarding the integration of the 72-hour assessment units, in the district hospital; and
- To determine the suggested improvements in district hospitals, in order to accommodate the 72-hour assessment units.

1.7. Operational definitions

For the purposes of this study, the following terms are used as defined below:

- **District hospitals:** are level 1 hospitals, which support primary health care and provide general services to in-patients and out-patients, and are the gateway to more specialist care (MHCA, 2002). In this study, district hospitals refer to two selected hospitals in the WC metropole, to which patients with mental illnesses are referred, for observation and assessment over a period of 72 hours, as stipulated in the MHCA (2002).
- **Experience:** refers to direct personal participation or observation, actual knowledge or contact, a particular feeling or impact made on an individual (Longman Contemporary English Dictionary, 2001). Soanes and Stevenson (2006) further define experience as, an accumulation of knowledge, or skills that result from direct participation in events, or activities known only to the person, who has lived through it and often makes an impression on the person. In this study, experience will share the same meaning as Soanes and Stevenson (2006).
- **Involuntary mental health care user:** is someone who is a danger to him/herself, or others, is deemed incapable of making an informed decision, due to his/her mental status and is unwilling to receive care, treatment and rehabilitation. This person is perceived to require such services for his/her own protection, or for the protection of others (MHCA, 2002). In this study an involuntary mental health care user is a person, who is admitted to the selected district hospitals, and is a danger to himself, or others.
- **Mental illness:** is a positive diagnosis of a mental related illness, in terms of accepted diagnostic criteria, made by a mental health care practitioner, authorised to make such a diagnosis (MHCA, 2002).

- **Professional nurse:** as a person who is educated and competent to practise comprehensive nursing, assumes responsibility and accountability for independent decision making in such practise, and is registered and licensed as a professional nurse under the South African Nursing Act (33 of 2005). In this study a professional nurse is a person, who is registered to provide care, treatment and rehabilitation services to mentally ill patients, when they are admitted to the selected district hospitals.
- **72-hour assessments:** are mental evaluations conducted on involuntary MHCUs, who are referred from community health care clinics to the district hospital, in order to initiate treatment and to decide on future care, treatment and rehabilitation (MHCA, 2002).
- **72-hour assessment units:** are the healthcare facilities or health establishments where 72-hour assessments of involuntary mental health care users should commence (MHCA, 2002). In this study, 72-hour assessment units are designated wards, or areas in the selected district hospitals, where 72-hour observation and assessments of involuntary MHCUs are conducted.

1.8. Research design and methodology

A qualitative approach, using a phenomenological descriptive design, was deemed most appropriate for this study, as the researcher sought the subjective exploration of reality from the perspective of the person experiencing the phenomenon. The research design and methodology for this study is explained in detail in Chapter Three of this thesis.

1.9. Data analysis

Data obtained for this study, was analysed using Tesch's method of data analysis. A more detailed description of the data analysis process is outlined in Chapter Four of this thesis.

1.10. Chapter outline of the study

The chapter sequence of this thesis is as follows:

In **Chapter One**, the researcher defines the study and provides an introduction to the study. The background and the rationale of conducting the study at the two (2) district hospitals in

the Western Cape metropole, is briefly explained. Also included in this chapter is the research problem, purpose of the study, aim, objectives and operational definitions and a brief exposition of the research methodology that was used in this study.

In **Chapter Two**, the empirical and theoretical literature is explored, relating to the experiences of nurses working in 72-hour observation and assessment units. This exploration includes the functioning of the 72-hour unit in a district hospital, experiences of nurses working in 72-hour observation and assessment units, and the changes necessary to accommodate involuntary mental health care users.

Chapter Three contains the research approach and methodology to achieve the aim of this research study. Details of the study design, sampling method, data collection method, and data analysis is presented, as well as a description of the measures taken to ensure the trustworthiness of the research.

In **Chapter Four**, the research findings are presented, as well as a discussion of the findings, which are contextualised.

Chapter Five comprises a summary of the findings, the conclusion and recommendations. The research gaps are identified and recommendations made for further studies. The limitations of the study are also considered and future research suggestions are discussed.

1.11. Conclusion

In this chapter, the researcher introduced the research study, outlined the background, as well as the aim and the significance of the study. Key concepts relating to this study were described and defined. The research methodology and design of this thesis was briefly presented.

Chapter Two comprises the literature review on the experiences of nurse working in the 72-hour assessment units, in general wards at district hospitals in the Western Cape metropole.

CHAPTER TWO

LITERATURE REVIEW

2.1. Introduction

In this chapter, the literature relating to professional nurses' experience of working in 72-hour assessment units is reviewed to contextualise the study. The purpose of a literature review, according to Polit & Beck (2010), is to become familiar with the knowledge base, which includes defining the scope of the review, identifying sources of information, reviewing the available literature, and conducting the review. In this study, the literature search included a review of data from books, articles, journals, written reviews and the available electronic databases of Google Scholar, PubMed, EBSCOHOST and Medline, in order to gather information on the topic. Both South African and international publications were searched. The focus of this study is on the experiences of professional nurses, working in the 72 hour assessment units, however, there is a paucity of literature in South Africa, as most of the available literature was written by members of the medical profession, who focus on other aspects concerning the implementation of the MHCA (2002), more than a decade ago.

2.2. Involuntary admission of MHCUs to 72-hour assessment units in general hospitals

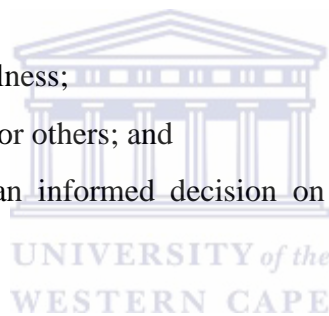
Mental illness is universal and patients presenting with a severe mental disorder, can be admitted, against their will, to a hospital, or place of safety, as alluded to in Chapter One. Globally, the involuntary admission of MHCUs has to follow a legislative process, in order for the patients to receive care and treatment, against his will, without violating their human rights.

In South Africa, before the promulgation of the MHCA (2002), the admission of psychiatric patients was governed by the Mental Health Act (No. 18 of 1973). A mentally ill patient with severe psychotic illnesses, who lacked insight and/or was opposed to treatment, was admitted to psychiatric hospitals in the following specific manner (Gillis, 1986). An application for certification had to be submitted to a magistrate, who would order a district surgeon and another medical officer to examine the patient. After studying and evaluating the documents, the magistrate would issue a reception order, which permits the person to be detained and

treated for a period, not exceeding forty-two (42) days (Gillis, 1986). This court process and the terms *certified* and *detained* caused stigmatisation of, and discrimination against, the MHCUs, as the protection of society was given priority over the rights of the individual (Burns, 2010). Since the promulgation of the MHCA (2002), in December 2004, the admission of involuntary MHCUs became simpler, as the process commenced at a level 1, or Primary Health Care Clinic (South Africa, Provincial Government of the Western Cape, Department of Health, 2009). MHCUs are involuntarily admitted to hospitals, when their functioning is severely impaired and their behaviour poses a threat to themselves and others, or when their families can no longer manage them (Yussof, Kuranga, Balogun, Ajiboye, Issa, Adegunloye & Parakoyi, 2008). The factors that will elicit hospitalisation for involuntary treatment care and rehabilitation are stipulated by the MHCA (2002) as follows:

When the MHCU:

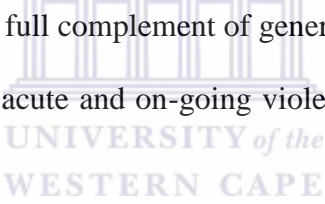
- suffers from a severe mental illness;
- refuses treatment;
- has no insight in his/her illness;
- is a danger to him/herself or others; and
- is incapable of making an informed decision on the need of care, treatment and rehabilitation services.



The establishment of 72-hour assessment units for MHCUs, who require a period of 72-hour observation, is aligned with the legislation and Regulations R.1467 of the MHCA (2002), as well as the policy guidelines on 72-hour assessment of involuntary MHCUs (South Africa, Department of Health [DoH], 2012). The restructuring and decentralisation of health care, with the focus on delivering health care at primary level, was initiated and proposed by the World Health Organisation (WHO) in 1970 with the Alma-Ata Declaration in 1978 (WHO & Wonca, 2008). In South Africa, the proposals were contained in the White Paper for the Transformation of the Health System in South Africa (SA DoH, 2010; Petersen, 2000; South Africa, Department of Health [DoH], 1997). The integration of mental health care into the general primary health services was promoted by the MHCA (2002), the Mental Health Policy Guidelines (SA DoH, 2012), and the Comprehensive Service Plan [CSP] (SA DoH, 2010a) of the Department of Health. The intention was to ensure improved access to the health system for the entire population and the development of community-based services (South Africa, Department of Health, 2010 [National Mental Health Policy Framework for

South Africa]; Petersen, Bhana, Campbell-Hall, Mjadu, Lund, Kleintjies, Hosegood, Flisher & the Mental Health and Poverty Research Programme Consortium, 2009).

The 72-hour assessment and observation of involuntary MHCUs is provided in the district hospitals, with subsequent provision for further involuntary care treatment and rehabilitation in psychiatric hospitals (SA DoH, 2012). District hospitals are Level 1 (L1) hospitals, where primary health care is provided (Janse van Rensburg & Jassat, 2011; South Africa [SA], Western Cape [WC], Department of Health [DoH], 2009). Beds are dedicated to provide 72-hour admissions, assessments and observations of MHCUs in the district hospitals (Petersen, *et al.*, 2009). This complies with the initiatives of the WHO and Wonca (2008), which indicate that a number of people with severe mental disorders will require hospitalization at some point in their lives. The district general hospitals are expected to deliver a full package of care, as they are situated in accessible and acceptable locations (WHO & Wonca, 2008). The Western Cape Department of Health (SA WC DoH, 2009) confirms that the package of care, specific to psychiatric services in level 1 (L1), or district hospitals, is:

- 
- To diagnose and manage a full complement of general psychiatric conditions;
 - To manage all aspects of acute and on-going violent, agitated or disruptive patients; and
 - To admit involuntary patients for 72-hour assessments and observations.

In accordance with international agreements and the obligations of the South African Constitution (Act 108 of 1996) and the Bill of Rights, the MHCA (2002) is obligated to provide care, treatment and rehabilitation to persons who are mentally ill, as well as implement various procedures for the admission for such persons, in order to protect them from unfair discrimination, while promoting and ensuring their maximum mental well-being. Petersen, Lund, Bhana, Flisher and the Mental Health and Poverty Research Programme Consortium (2011) view the introduction of a 72-hour assessment and observation referral service for emergency psychiatric patients in designated general hospitals, as an improvement in health service delivery in South Africa.

2.3. Challenges related to the provision of 72-hour observations in general hospitals

Psychiatric nursing is a specialised field that requires specialised knowledge, skills and expertise to deliver care, treatment and rehabilitation services to MHCUs. Literature reviewed, universally, on the management of MHCUs, revealed that service delivery was compromised, with patients being treated in sub-optimal settings and inadequate human resources in the facilities, where patients suffering from a mental illnesses, were managed (Chakravarty, Menchine Thompson, Rajeev, Santos (2013); Browne *et al.*, 2010). Many studies were conducted in South Africa to assess the impact of the MHCA (2002) on services, patients and personnel in the primary health sector, as the level 1 (L1) services were mostly affected by the integration of mental health into primary health care (Petersen *et al.*, 2011); Janse van Rensburg, 2010); Ramlall *et al.*, 2010; Burns, 2008). This integration poses an even greater challenge to facilities and personnel, as patients with psychotic and aggressive behaviour have to be managed in a general hospital (Petersen *et al.*, 2009). In South Africa, many problems were documented with the admission of MHCUs to district hospitals throughout the country (Petersen *et al.*, 2011). Although the principles and validity of the MHCA (2002) are sound, as confirmed by Burns (2008), there are infrastructural, as well as functional shortcomings and deficiencies in the district hospital service. This was confirmed in studies conducted by Petersen *et al.* (2009; 2011) and Lund, Kleintjies, Kakuma and Flisher (2009), alluding to significant service gaps, in and across the provinces of South Africa. The same authors raised a general concern about the lack of a designated area, or specialist unit, for psychiatric patients, who were managed in the general wards of district hospitals. A study conducted by Janse van Rensburg (2010) revealed that, while major changes to the extent and scope of services in general regional hospitals were expected since the promulgation of the MHCA (2002), no additional resources have been made available. The district hospitals encounter serious problems in providing 72-hour assessments and observations, which leads to sub-optimal levels of care and occasional disasters (Burns, 2010).

Globally, a safe environment, as well as the safety of patients, staff, visitors and equipment is a priority for nursing staff (Seed, Torkelson & Alnatour, 2010). However, the majority of psychiatric patients admitted to hospitals are unpredictable and often unstable (Howard & Holmshaw, 2010). Aggression is a display of violence, which could be directed at self, others or objects, and is a common feature in wards with psychiatric patients (Gule, 2012). In a

study conducted by Seed *et al.* (2010), the role of the psychiatric nurse delivering acute care was described as demanding and complex, because there is the expectation of a safe, structured and supportive environment for a diverse mix of patients. Even in non-psychiatric settings, nurses are frequently expected to provide care to patients with mental health and behaviour management issues (Petska, Hatteberg, Larson, Zwycart, Cox & Borgen, 2012).

A survey conducted in KwaZulu-Natal, South Africa by Ramlall, Chipps and Mars (2010) described the management of disruptive patients in a general ward setting as challenging. The high incidence of substance abuse in the Western Cape, as surveyed by Herman, Steyn *et al.* (2009), increases the incidence of aggressive and psychotic behaviour of MHCUs even further. The management and containment of disturbed and aggressive patients is magnified by absence of adequate facilities (Burns, 2010).

A study conducted by Petersen *et al.* (2011) reviewed mental health service delivery in South Africa and revealed that the shortage of beds, the lack of resources, inadequate budgets and facilities were still evident. Ramlall *et al.* (2010) questioned whether district hospitals comply with the requirements of providing 72-hour admission, assessments and observations to MHCUs and concluded that the facilities in 63.9% of hospitals were not appropriate, or adequate, to deliver psychiatric services, referring to insufficient dedicated beds, the lack of seclusion rooms and inadequately refurbished hospitals. The same survey revealed that 75% of the MHCUs admitted to designated hospitals, were involuntary or assisted patients, indicating that district hospitals cater, almost exclusively, for the most severe mentally ill population (Ramlall *et al.* 2010).

Observations made by Chakravarty *et al.* (2013) in the Emergency Department of hospitals in the USA revealed that psychiatric clients are “loud” and had to wait a long period in the ED, before being transferred, even after they were medically stabilized. The same authors alluded that these long delays in an unhealthy environment, caused a high incidence of symptom escalation, resulting in chaos (Chakravarthy *et al.* 2013). In Australia, Browne *et al.* (2010) established that the excessive lengths of stay (LOS) in the ED were problematic. In South Africa, the delays in the transfer of MHCUs to the appropriate level of care from district hospitals were a reality, with the average length of stay being 15.4 days (Janse van Rensburg, 2010). Besides the fact that MHCUs stay for long periods in the hospital, the same survey, conducted in 2007/2008, affirmed that district hospitals experienced an increase in the

number of admissions of acutely ill MHCUs. The burden on resources and service delivery increased even more with the 8% patients, who were readmitted and kept for longer periods in the district hospitals (Janse van Rensburg, 2010).

Nursing ratios in the 72-hour units were below the WHO norm, with the average nursing staff member on duty having to carry the load of 2 to 3 workers, which escalated potential risk elements (Janse van Rensburg, 2010). The staff shortages were exacerbated by nurses not being exclusively utilized to perform nursing tasks (Petersen *et al.*, 2009). The process of involuntary admission and 72-hour assessment involved a huge administrative burden with lots of paperwork to complete (Ramlall *et al.*, 2010). Nursing care, therefore, was compromised with only the most essential nursing tasks being performed, as there was no time for individual case management, group therapy, health education or attending ward rounds (Janse van Rensburg, 2010). The times spent on therapeutic activities were fraught with interruptions, multi-tasking episodes and paperwork that prevented nurses from developing therapeutic relationships with their patients, although it was perceived as one of the most important aspects of their nursing role (Seed *et al.*, 2010).

The findings of a study conducted by Petersen *et al.* (2011), which focused specifically on the 72-hour observation and emergency care of mental users, revealed that specialist personnel were mostly inadequate in providing the 72-hour emergency management and observation service in general hospitals. A study conducted by Petersen *et al.* (2009) revealed that psychiatric patients were cared for by nurses with varying degrees of experience, because of the rotation of psychiatric nurses throughout the hospital.

An additional burden on the 72-hour unit was the mixed patient profile. This not only refers to the different legal categories of MHCUs admitted to the district hospitals, but also the frequent co-morbidity of medical conditions, and/or substance abuse disorders coupled with psychiatric illnesses (Janse van Rensburg, 2010). The author alluded to the increased demands on nursing staff with the admission of medical patients, involuntary MHCUs, adolescents and psycho-geriatric patients together in one confined area, in an acute mental health care unit (Janse van Rensburg, 2010). Another shortfall identified in this study was the lack in child and adolescent mental health services (Petersen *et al.*, 2011).

Mental illness is associated with stigma and discrimination, which is evident among general health care workers and primary health care nurses (Petersen *et al.*, 2009). MHCUs are branded as being violent, unpredictable and sometimes responsible for their-own illness (Frisch & Frisch, 2011). Health care workers, who lack competence and confidence in identifying and managing mental illness, display negative attitudes towards patients with mental illnesses (Petska *et al.*, 2012). The negative attitudes, discrimination and stigmatisation by health care workers, causes them to avoid and dismiss the psychiatric patients, rather than provide care, because they do not know how to (Petersen *et al.*, 2009). These factors lead to an unpleasant and negative experience for the service users, which includes the unavailability of therapeutic interventions, unpleasant constructed environments, staff being too busy, the stigma of a psychiatric admission, as well as the experience of being admitted involuntarily (Osborne, Lloyd-Evans, Johnson, Gilbert, Byfort, Leese & Slade, 2010). Much needed improvements in the 72-hour assessment units would, therefore, benefit the patients, as well as the staff.

2.4. Improvements to increase patient care and staff satisfaction

A study conducted by Seed *et al.* (2010) with psychiatric nurses reveals that there is a link between the ability to provide effective patient care, positive patient outcomes and increased job satisfaction. Student nurses, who lack knowledge and confidence, experience anxiety, but as their training progresses and experience grows, their stress levels are reduced (Sharif & Masoumi, 2005). Repeated positive experiences could alter attitudes, making nurses feel confident about providing quality care (Dean & Meocevic, 2006).

In order to reduce the risk of job related violence, Petska *et al.* (2012) suggests that nurses should receive additional education and increased exposure to specialized care units, as well as patients with mental health issues should be encouraged. A survey conducted by Ramlall *et al.* (2010) established that 30% of the hospitals reported that the staff received adequate support to provide 72-hour observations, and about 50% of the hospitals reported their staff received adequate training in the MHCA (2002). Seed *et al.* (2010) proposes that the amount of paper work should be reduced, and the time spent on direct patient care should be increased, to ensure job satisfaction. The same study revealed that improved communication among the health team members, sound working relationships with peers, competence of physicians and staff, enhanced job satisfaction. Therefore, it is clear that factors such as,

adequate staff support, sufficient available staff, good working relationships, providing efficient quality care to patients and experiencing improved progress in patients' health, will increase staff satisfaction.

The Comprehensive Service Plan (CSP) of the Western Cape Department of Health (2010a) outlines the specific level of care in a proper infrastructure for patients presenting with confusion, agitation and behaviour disturbance. The policy guidelines that outline and guide the procedural and the infrastructural requirements for 72-hour assessments and observations of involuntary MHCUs, was only published in 2012 (SA DoH, 2012).

Positive outcomes in patient recovery were reported with the implementation of applicable therapeutic interventions in a therapeutic milieu. A study conducted in Norway, in an acute adolescent psychiatric admission unit, revealed that a therapeutic milieu (environment), in which the patient was treated and the therapeutic interventions, influenced patient recovery. In the study, the comprehensive, age customized treatment, with a complex set of multiple interventions, was provided in a therapeutic milieu and coupled with specialized education, which resulted in a patient's shorter stay in hospital, with increased improvement in their mental health (Hanssen-Bauer *et al.* 2011). A study conducted by Browne *et al.* (2011) at the Royal Melbourne Hospital, a Psychiatric Assessment and Planning Unit (PAPU) was established to improve access to psychiatric care for patients admitted via the Emergency Department (ED). A better standard of care was provided to psychiatric patients, in a more appropriate setting in the least restrictive environment. The unit was staffed by a multi-disciplinary team, to whom the patients and their families were allowed access. Since the opening of the PAPU, the following resulted:

- a) A reduction in the length of stay;
- b) A reduction in one-to-one nursing hours, as is expected in the ED, with huge cost savings;
- c) A reduction of more than 50% in mechanical restraint (from 197 hours to 35); and
- d) A reduction in unarmed threats (Code Greys), being an indication of physical restraint.

The PAPU has led to the provision of a better standard of care, in a more appropriate and therapeutic environment (Browne *et al.*, 2011).

2.5. Conclusion

In this chapter, a review of literature relating to the process of the admission and assessment of involuntary MHCUs, the challenges related to the provision of 72-hour observations in general hospitals, and the suggested improvements to increase patient care and staff satisfaction in the 72-hour assessment units in district hospitals, was presented. Although limited information was available on the experiences of professional nurses, working in the 72-hour assessment units in district hospitals, the available studies could be utilised to inform the approach to the study, as well as the researcher's own work.

In Chapter Three, the research methodology adopted for this current study is discussed. A description of the research design, methodology, data collection, data analysis, trustworthiness and ethics considerations are discussed.



CHAPTER THREE

RESEARCH METHODOLOGY

3.1. Introduction

In this chapter, an overview is presented of the research methodology, used to achieve the aim of the study, namely, to explore and describe the experiences of professional nurses working at selected district hospitals in the Western Cape, where 72-hour assessments of involuntary MHCUs are conducted. A qualitative research approach, with a descriptive phenomenological design, was employed in this study. Creswell (2013) asserts that a researcher can explore a problem, or issue, of a particular group, or population, where the variables cannot be easily measured through quantification, by using a qualitative research methodology. An exposition of the methodology utilised in this study is provided as follows:

- research approach and design
- research setting
- population
- sample and sampling strategy, sample size
- data collection instrumentation and process
- data analyses

The chapter is concluded with a discussion on the qualitative rigour, namely, trustworthiness and reflexivity, and ultimately, a conclusion.

3.2. Qualitative research approach

Qualitative research is an enquiry process of understanding a social, or human problem, in which a complex and holistic picture is built through narratives from its participants, while being conducted in a natural setting (Creswell, 2013). The narratives are subjective (Polit & Beck, 2012). In this study, the researcher's role was one of an active learner, who tells the story from the participants' viewpoint, as opposed to being an 'expert', who passes judgement on the participants. Some of the core characteristics that define qualitative research are:

- Data are collected in a natural setting, which implies that the researcher interacts, face-to-face, with the participants, talking to them and observing how they behave in their context;
- The researcher is the key instrument, as the researcher is usually the one, who actually gathers the information;
- Multiple forms of data, such as interviews, observation, documentation and audio visual information are usually gathered, instead of relying on a single data source;
- Researchers do inductive, as well as deductive analysis, by building their patterns, categories and themes from the bottom up, organising the data into increasingly more abstract units of information;
- Emphasis is totally focussed on the participants' conception of the problem, or issue;
- The research process is emergent, as the problem, or issue is learnt from the participants and explored in the research to obtain the information;
- Researchers reflect on their role in the study and their personal background; and
- Qualitative researchers maintain a holistic account, by generally sketching the larger picture that emerges (Creswell, 2013).

The researcher chose a qualitative research design to provide the professional nurses, working in the 72-hour units in district hospitals, with an opportunity to verbalise their in-depth personal experiences, in order to unearth the insider views of the participants.

3.3. Descriptive phenomenological design

Phenomenology is a philosophy, as well as a perspective and an approach to practice and research (Munhall, 2012). According to Polit & Beck (2012), phenomenology focuses on the meaning of the lived experiences of humans, and emphasizes the dynamic, holistic and individual aspects of human life, revealing rich, in-depth information that can elucidate a phenomenon. Additionally, the primary objective of a phenomenological study is to explicate the meaning, structure and essence of the lived experiences of a person, or group of people, around a specific phenomenon (Christensen, Johnson & Turner, 2010).

In phenomenology, the two main schools of thought are descriptive and interpretive phenomenology (hermeneutics). Edmund Husserl (1962) developed descriptive

phenomenology, which emphasizes the descriptions of human experience, using bracketing, intuiting, analysing and describing (Polit & Beck, 2013). Heidegger, a student of Husserl, in contrast with his teacher, moved into interpretive phenomenology of hermeneutics, where bracketing does not necessarily occur, but which ideally approaches each interview text with openness (Polit & Beck, 2013). The goal of phenomenological research is not to describe or ground theory, or to develop a model, but it is to describe, accurately, a person's 'lived' experience in relation to what is being studied (Balls, 2009). A descriptive phenomenological research approach suited the current study best, as describing the lived experiences of professional nurses, who worked in 72-hour assessment facilities in district hospitals, was the central focus of enquiry.

3.4. Research methodology

Research methodology focuses on the techniques used by researchers to structure a study, as well as to gather and analyse information, relevant to the research question (Babbie & Mouton, 2014). In this study, the researcher used semi-structured interviews to collect data.

3.4.1. Research setting

The study was conducted at two district hospitals, one peri-urban (Hospital A) and one urban (Hospital B) in the metropole region in the Western Cape (Appendices E & F), where, in total, ten district hospitals offer 72-hour assessments of MHCUs. Hospital A is a 162 bedded hospital, situated in the Eastern sub-structure of the Western Cape metropole. Two small wards, which were originally one 4-bed and one 6-bed ward in the general ward, are allocated to admit all categories of MHCUs. Trolley beds are utilised, as more psychiatric patients can be accommodated in this way. At times, up to 18 patients are admitted in the bigger ward, with the overflow of patients having to sleep on mattresses on the floor. There are no seclusion facilities in this hospital. Hospital B is a 322 bedded public hospital, situated in the northern suburbs of Cape Town. Services provided by the hospital include the admission and treatment of patients with trauma and medical emergencies; physical illnesses; orthopaedic and minor surgical interventions; maternity - and obstetrical services; as well as the observation, assessment and referrals of people with mental illness. In this hospital, 36 beds are allocated for the psychiatric patients. All categories of psychiatric patients, including the involuntary MHCUs, admitted for a 72-hour observation and assessment

period, are accommodated in the two separate wards catering for 18 females and 18 male patients. There are no seclusion facilities for female patients. Besides, adolescent male psychiatric patients are accommodated in a single room of the ward designated for females.

3.4.2. Population

A population is the entire set of individuals, objects, events or elements that meet the sampling criteria for inclusion in a study (Grove, Burns & Gray, 2013). The population for this study were the professional nurses working in the 72-hour assessment units of the two selected district hospitals. This category of staff was selected because they were the nurses, who were directly responsible for the care, treatment and rehabilitation of MHCUs.

3.4.3. Sampling method

Sampling is the process of selecting cases to represent an entire population (Polit & Beck, 2012). In this study, the sampling method was purposive, as the targeted group had the characteristics and experience of the phenomenon, which was a requirement for inclusion in the study. Purposive sampling means that the researcher selects individuals and sites for the study, purposefully, as the selected individuals understand the research problem and central phenomenon of the study (Creswell, 2013).

3.4.3.1. Inclusion and Exclusion criteria

The inclusion criteria specify the characteristics of the population that the research includes in the study (Polit & Beck, 2012).

The inclusion criteria for this study were:

- Participants must be registered nurses with the SANC;
- Participants must be permanent employees of the Department of Health;
- Participants must be working in the 72-hour assessment facilities in the selected district hospitals; and
- Participants must have volunteered to participate in the study.

The Exclusion criterion was:

- Professional nurses employed by nursing agencies and part-time professional nurses.

3.4.4. Sample size

Sample size is the number of participants involved in the research (Polit & Beck, 2012). According to Creswell (2013), consideration for sample size in qualitative research is to study a few individuals and collect extensive detail about each studied individual, until data saturation is reached. Data saturation determines sample size (Munhall, 2012). Saturation of data occurs when additional sampling provides no new information, but only redundancy of previously collected data (Polit & Beck, 2012). Data saturation for this study was reached after eight (8) participants were interviewed.

3.4.5. Data collection method

Data collection is a systematic gathering of information that is relevant to the research aim, research objectives and research questions (Polit & Beck, 2012). In this study, data were collected by means of semi-structured interviews.

3.4.5.1. Recruitment of participants

Permission to conduct this study was obtained from the Research and Ethics Committee at the University of the Western Cape (Appendix A). Permission to conduct the study at the selected district hospitals was sought (Appendix B) and obtained (Appendices C & D) from the Department of Health. The researcher made telephonic contact with the managers of the two selected hospitals to inform them about the study and gain access to the potential participants. On arrival at the hospitals, the managers introduced the researcher to the professional nurses on day duty. The researcher explained the purpose of the study and handed out information sheets (Appendix G), which explained the aim, objectives and questions to be asked, during the interviews. The information sheet also referred to the potential risks associated with participation in the study, as well as the measures that the researcher would undertake to minimise harm, for example, referral to a therapist/counsellor. The relevant contact details of the study leaders and Dean of the Community Health Sciences (CHS) faculty were also included. The professional nurses were invited to participate in the study. The researcher returned to the hospitals during the evening to inform the professional nurses on night duty about the study and to distribute information sheets. Appointments were made with both day and night duty professional nurses, who indicated their willingness to participate in the study. Of all the nurses approached, eight (8)

agreed to participate in the study. Appointments that were made with the participants indicated their most convenient time and place for the interviews to be conducted.

3.4.5.2. Data collection instrument

In this study, semi-structured interviews were conducted to explore and describe the experiences of nurses working in 72-hour assessment units at the selected district hospitals. A semi-structured interview is a method of qualitative inquiry that combines a pre-determined set of open-ended questions to obtain a detailed picture of a particular phenomenon (Creswell, 2013). Semi-structured interviews were used in this study, because the researcher wanted to gain a better understanding, by extending beyond the format of questioning, through the technique of probing the participants' experience of working in 72-hour assessment units.

In semi-structured interviews, the participants are encouraged to talk freely about the topics on the pre-set topic guide, and to tell their stories in their own words (Polit & Beck, 2012). Prior to the interviews, an interview schedule (Appendix I) was prepared to answer the aim of the study. Careful thought was given to the compilation of questions about the topic, with probes included to elicit additional detailed information about the nurses' experiences of working in a 72-hour assessment unit.

3.4.5.3. Data collection process

Data collection took place from September to December 2015. Interviews with the participants from hospital A were conducted in the professional nurses' office, staff tearoom and an office near the emergency department. Interviews with the participants in hospital B took place in the professional nurses' offices. The researcher conducted the semi-structured interviews.

Prior to commencement of the interviews, the researcher reoriented the participants to the purpose of the study, as they had received the participant's information sheets, during the initial contact as mentioned previously. The participants were given an opportunity to clarify aspects that they were unclear

about and to ask for additional information. Thereafter, the participants signed the Informed Consent forms (Appendix H). The researcher asked the participants for permission to use the voice recorder, during the interview, so that the interviews could be recorded for data analysis, so that no information was lost, or overlooked. All the participants agreed. A cell phone was used to audio tape the interviews. During the interviews, the researcher and the participants had the opportunity to perceive, interact, reflect, attach meaning and substantiate evidence, and clear up uncertainties. Probes were used to elicit better understanding and explore deeper meaning. Unfortunately, the available areas that the participants indicated as suitable were noisy, with varying degrees of disturbances. The interviews were interrupted, as some of the participants had to conduct nursing activities, because they were the only professional nurse on duty in the ward, at that time. Each interview lasted between 25 and 45 minutes. Data saturation for this study was reached after eight (8) participants were interviewed although two participants were interviewed twice as points of clarity were sought. Data saturation occurs when there are no new emerging themes from participants (Creswell, 2013).

Field notes were made after each interview to enhance the richness of the data gathered, by creating a detailed record of all the occurrences, during the interview, as indicated by Holloway & Wheeler (2010). Reflective notes regarding each interview conducted, was recorded by the researcher, after each interview, in a personal reflective diary. The researcher recorded these reflective notes, in order to ensure that every detail, regarding the interviews, was captured accurately, and to ensure that an audit trail of each interview was captured.

3.5. Data analysis

During data analysis, data are organised and structure is provided to elicit meaning from the data collected (Polit & Beck, 2012). The analytical procedures, according to Polit & Beck (2012), involves: data management, which is reductionist in nature, whereby masses of data is converted into smaller, manageable segments; and data analysis, which involves putting segments together into meaningful concepts. Tesch's method of identifying themes was used to analyse the data in this study. This method provides a useful structure through which some

order may be created (Babbie & Mouton, 2014). The process of analysing textual data as is described by Tesch (Creswell, 2009) occurred as follows:

- **Step 1:** In the first step, data is organised and prepared for analysis. The researcher became immersed in the data to portray it a form that could be analysed. The researcher listened to the audio-recordings of the interviews to check for audibility and completeness. The researcher and an independent person, subsequently, transcribed the recorded the data verbatim (word by word), with the researcher continuously verifying the accuracy of the transcripts (Creswell, 2009). The transcripts were also dated and labelled. The first two transcripts were analysed by both the researcher, as well as the researcher's supervisor, to verify for accuracy of the transcripts, and to ascertain whether the interview process revealed adequate data.

To get a sense of the whole, the researcher listened to the recorded interviews many times. The researcher then read all the transcripts carefully. Some ideas were noted as they came to mind. These ideas were then compared with the non-verbal expressions that were noted and reflected in the field notes, during the interviews.

- **Step 2:** The second step is to read all the data to get a general sense of the information and to reflect on the overall meaning (Creswell, 2009). The researcher read the first two scripts with the help of the study supervisor and received guidance on the understanding of the qualitative data analysis process. The researcher started analysing the data, by carefully reading all the transcriptions, in order to gain a sense of the whole cache of information. Subsequently, the transcripts were stacked – the first interview transcript on top of the pile and the last one, at the bottom. The researcher started reading the first transcript, while asking the question, “What is the nature of this?”, and making notes in the margins of thoughts that emerged about the data. This process was repeated with all the transcripts. A list of topics was made and related topics were clustered together.
- **Step 3:** This step involves the coding process of text data being placed into categories (Creswell, 2013). The coding of themes and sub-themes occur at this stage in the data analysis process; therefore, codes were assigned to each of the transcripts. The researcher made a list of all the topics; similar topics were clustered together. This method of coding data is referred to as reductionist. The researcher, subsequently,

took the list back to the data. Topics were abbreviated, as codes and categories were assigned to the appropriate segments of the text. This preliminary organizing scheme was performed to assess whether new categories and codes would emerge.

- **Step 4:** In this step, codes are assigned to the topics. According to Creswell (2009), the coding process provides a description of the setting, or people, and generates categories, or themes for analysis. The categories, or themes, reveal major findings, supported by several quotations. The researcher and the research supervisor reviewed the data to make judgments and interpretations of the content, as well as meaning of the material (Patton, 2002). Categories were assigned to the codes, grouping them and indicating interrelationships. Themes and sub-themes emerged from these categories.
- **Step 5:** The emerging concepts, or findings, of the analysis are discussed in narrative form, in step 5 (Creswell, 2009).
- **Step 6:** In this step, the data was interpreted. The entire analysing process was executed by the researcher, in constant and continuous consultation with the research supervisor.

A literature control was conducted to compare the collected data with existing research findings.

3.6. Reflexivity

Munhall (2012) defines reflexivity as the process, through which researchers identify that they are an integral part of the research and vice versa. According to Harding (2013), reflexivity enhances the validity of qualitative research. A comprehensive and detailed account of decisions made during the research process was prepared to ensure that the quality of the researcher's work could be assessed by others. The researcher kept a research diary, in which key decisions and notes were entered.

3.7. Trustworthiness

Munhall (2012) recommends that the researcher ensure a high quality of rigour in the study by adhering to the criteria for trustworthiness, namely, credibility, transferability, dependability and confirmability. These criteria were applied in this study as follows:

3.7.1. Credibility

Credibility is evidenced in prolonged engagement, persistent observation, member checking, triangulation and peer debriefing (Munhall, 2012). The researcher of this current study established truth-value by using semi-structured interviews and was involved for a prolonged period. The credibility was enhanced by member checking of the interview transcripts; the participants were given their transcripts to confirm accurate translation of their views. The researcher kept reflective notes.

3.7.2. Transferability

The researcher ensured applicability by giving a detailed description of the study to ensure that the reader is familiar with the context of the study (Botma, Greeff, Mulaudzi & Wright, 2010). The researcher established transferability by offering a dense description of the research study, as well as by ensuring data saturation.

3.7.3. Dependability

Consistency was ensured through a dependable audit trail and by providing a dense description of the research methodology. In this study, the co-coding was done by the researcher and the research supervisor, in order to minimise bias during the data analysis process.

3.7.4. Confirmability

According to Munhall (2012), an audit trail of methods and decisions from a reflective journal provides evidence of confirmability. The researcher established confirmability, which is a strategy of neutrality, by ensuring actual quotes from the participants, through triangulation and reflexivity and by keeping an audit trail.

3.8. Ethics

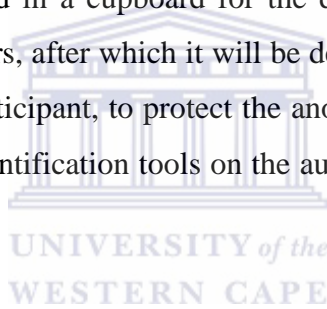
Ethics approval to conduct this study was obtained from the Research and Ethics Committee of the University of the Western Cape (Appendix A). Permission to conduct the study in the two selected district hospitals was obtained from the research committee of the Department of Health (Appendices C & D). The Chief Executive Officers of the respective district hospitals gave telephonic permission to conduct the study in the hospitals, as they were aware

of the study. The participants gave permission by signing informed consent forms (Appendix H) after obtaining information about the study (Appendix G).

During the planning and implementation phase of the research process, the researcher strived to conduct the research in an ethical manner. The following ethics principles were adhered to:

3.8.1. Confidentiality and Anonymity

The researcher ensured confidentiality by preventing the linking of data gathered during the study to individual participants and guaranteed that their names would not be disclosed in the study. The researcher removed all identifiable information from the transcripts by allocating a number to each participant and refraining from identifying the district hospital. To ensure confidentiality, all audio tape recordings, transcripts, the researcher's reflective journal notes, as well as all written notes pertaining to this research study, were locked in a cupboard for the duration of the study, and will be securely stored for five years, after which it will be destroyed. The researcher made use of study codes for each participant, to protect the anonymity of participants. The study codes were also used as identification tools on the audio recording tapes, as well as the transcripts.



3.8.2. Autonomy

The participants' right of autonomy through self-determination was respected. Participation in the research process was voluntary and participants were informed of their right to withdraw from the study at any stage of the process, without prejudice or penalty.

3.8.3. Justice

The selected participants were related to the study, as all worked as professional nurses in the 72-hour facilities of the district hospital and, therefore, met the criteria for inclusion.

3.8.4. Consent

The ethical principle of voluntary participation and protecting the participants from harm was upheld by providing the participants with a written account, as well as clear verbal information about the study. The participants were also informed that the

interviews would be audiotape recorded. The researcher ensured that each participant understood the process, before giving written consent to cooperate in the study.

3.8.5. Privacy

The interviews were held in an area that was meant to be private; however, there were many disturbances and noise.

3.8.6. Risk

There are risks associated with all studies; therefore, the participants were informed that should they be in need of emotional support, a therapist/counsellor, whom the researcher had briefed beforehand, would be on standby for debriefing sessions. All the participants declined this service, claiming that they were not traumatised, as the opportunity to communicate their experiences was cathartic to them. No reward was offered, or paid, to the participants for their involvement in this research study.

3.10. Conclusion

In this chapter the research methodology was described. A qualitative approach, with a descriptive phenomenological research type, was applied to investigate the experiences of the participants working in 72-hour assessment units at the two selected district hospitals in the Western Cape metropole region. Semi-structured interviews were used to give each participant an opportunity to share their experiences.

In Chapter Four, the results obtained from the analysed data are presented.

CHAPTER FOUR

RESULTS AND DISCUSSION OF FINDINGS

4.1. Introduction

The results of the analysed data collected from the study participants are presented in this chapter. In addition, a discussion of the findings will be provided. A descriptive phenomenological research design was used in this study to explore and describe the experiences of professional nurses, working in 72-hour assessment units at two selected district hospitals in the Western Cape. The presentation and discussion of findings will elaborate on the identified categories, sub-themes and themes that emerged during the data analysis. A literature control will be used in the discussion of the findings to aid in the contextualisation of the findings. This chapter is divided into two sections:

- Section A, provides the participant profile; and
- Section B, tabulates the themes, sub-themes and categories that emerged from the participants' interviews and includes a narrative of the participants' responses with verbatim quotes of their experiences of working in the 72-hour assessment units.

Ten (10) semi-structured interviews were conducted with eight (8) participants, who met the inclusion criteria for this study. The interviews were conducted between the period of September and December 2015.

SECTION A

4.2. Participant profile

Eight (8) *professional* nurses (Seven (7) females and one (1) male) from two district hospitals in the Western Cape metropole, participated in this study. Three (3) participants had achieved baccalaureate degrees in nursing, while five (5) participants had achieved a diploma in nursing. Two (2) participants had post-basic psychiatric nursing qualifications. Five (5) participants were clinical nurse practitioners, while two (2) participants were operational managers. The participants' ages ranged from 25 years to 58 years. The participants' work experience as professional nurses ranged from 2 – 35 years.

SECTION B

4.3. Professional nurses experience of working in 72-hour assessment units

Table 1 below depicts the categories, themes and sub-themes, which represent the experiences of the participants in this study.

Table 1: Professional nurses experience of working in 72-hour assessment units

Theme 1: Patient management processes affected the functioning of the unit	
Sub-themes	Categories
1.1. Referral pathway of involuntary MHCUs	Admission of MHCUs occurred from primary health care facilities or directly from their place of residence.
	Internal transfers of involuntary MHCUs from casualty or emergency departments were prioritised because of their unpredictable behaviour.
	External transfers of patients to tertiary hospitals were due to aggression and non-adherence to treatment.
	Assessment of MHCUs within the 72-hour period was perceived by participants to be advantageous for patients and the family.
1.2. Safety measures to exercise social control	Chemical restraint for aggressive behaviour was administered to ensure the safety of the MHCU, fellow patients and staff.
	Physical control of patients was enhanced through supervision and the presence of security guards
	Patients were physically restrained by means of seclusion when they were perceived to be dangerous or an abscond risk.
Theme 2: Patient management challenges in rendering nursing care	
2.1. Lack of physical resources and noise pollution	Limited physical space to accommodate patients resulted in overcrowding and patients sleeping on trolleys.
	The location and lay-out of the unit, impeded the participants' ability to render effective patient care.
	Noise pollution affected the recovery process of the MHCUs
	Lack of physical facilities to conduct therapeutic programmes resulted in staff being frustration.
2.2. Lack of staff, knowledge and skills	Shortage of nursing staff increased the participants' workload and responsibility of caring for patients
	Rotation of staff led to increased workload of participants.
	Perceived lack of stakeholder competency in the completion of regulatory forms increased participants' workload.
	Lack of de-escalation skills to manage aggression made support staff vulnerable to assault.

2.3. Long periods of hospitalisation	Lack of beds at tertiary hospitals resulted in long waiting lists.
	Delay in transfer of acutely mentally ill patients caused a sense of helplessness in participants.
	Participants felt the patients who were discharged prematurely were treated unfairly.
Theme 3: Burden of caring on the Self	
3.1. Experience of emotional strain	Participants became frustrated at caring for both mentally and physically ill patients who were accommodated in one ward.
	The admission of different legal categories of MHCUs resulted in participants experiencing a burden in caring.
	Participants questioned themselves about the mental health care that they delivered to the MHCUs.
3.2. Stigma related to mental illness	Participants reported being stigmatised due to working with MHCUs.
	Participants experienced a sense of failure in their patient advocacy role when MHCUs were stigmatised.
Theme 4: Staff and patient support to create a therapeutic environment	
4.1. Staff retention and development	Trained permanent staff to create stability and improved patient outcomes.
	In-service training for staff regarding de-escalation techniques to manage aggressive patients.
	Adequate human resources to manage diverse patient population
	Improved lines of communication between medical, nursing staff and management regarding patient care.
4.2. Provision of physical and therapeutic resources	Attractive adequate, safe, physical environment to improve patient care
	Initiation of therapeutic programmes to improve patient care
	Provision of nursing care to patients with medical illness and psychiatric illness in separate facilities to improve patient outcomes.

4.3.1. Theme 1: Patient management process affected the functioning of the unit

The patient management process comprised two sub-themes namely, referral pathway of involuntary MHCUs and safety measures to exercise social control, was inductively elicited during the data analysis process.

4.3.1.1. Sub-theme 1.1: Referral pathway of involuntary MHCUs

The referral pathway alluded to the process of referral of involuntary MHCUs from primary health care facilities to the district hospitals for 72-hour observations. Prior to admission into the 72-hour assessment unit, MHCUs were

referred for admission from primary health care settings, places of residence and tertiary hospitals, as mentioned by a participant:

“The patients come in from different areas outside to the EC [Emergency Centre] here and then seen here by the EC doctors and then they come up here to the ward” (P06).

Staffs were unable to plan for the number of patients they received in the 72-hour units, as they had no control over how many MHCUs were admitted. The number of patients admitted was perceived to be an *“influx of patients”* (P03) that increased the burden on health service delivery, which affected the nursing care rendered to the MHCUs. After their admission to the district hospitals, MHCUs were transferred from the casualty, or emergency departments, to the 72-hour assessment unit. The behaviour of involuntary MHCUs in the casualty, or emergency departments, necessitated priority attention, as the following participants asserted:

“They are normally seen immediately by the doctor or tried to be seen immediately to prevent them from getting aggressive or agitated there” (P06).

“We can’t really send them anywhere else in the hospital, so, if they lie in casualty, they cause havoc there” (P01).

The 72-hour assessments unit in hospital A, comprised of two rooms which were originally a one four-bedded and one six-bedded room in the general medical ward. These rooms were converted by removing the curtain screens around the beds and replacing the beds with trolley beds. In hospital B, a separate male and female ward was recently allocated for the admission of MHCUs.

External transfers occurred between the district hospitals and level 1, 2 or 3 hospitals. MHCUs’ condition and behaviour predicted transfer for further care, treatment and rehabilitation services. This was especially essential when MHCUs presented with aggressive and violent behaviour, which could not be contained, and posed a safety risk, as there were no seclusion facilities in most of the 72-hour assessment units. However, participants alluded to the fact that the psychiatric hospitals being fully occupied. The result thereof was that staff at the

72-hour assessment units had to endeavour to contain the MHCUs with behavioural disturbances. Nevertheless, when MHCUs could not be contained, due to extreme destructive behaviour, they were considered an “*emergency*” and as such, were transferred to a psychiatric hospital. This was done to ensure the safety of the affected MHCU, fellow MHCUs and staff, as mentioned by a participant in the following excerpt:

“...If we usually have an emergency, we also link with [tertiary hospital X] now, to take some of our patients, but on [at] this stage, they’re also full...if we have a real difficult patient that is breaking off [destroying] the room, because we don’t have a place to keep them safe, or the other patient safe, then we try to push them [transfer] over for emergency” (P01).

Although the mental condition of some MHCUs improved during their stay in the 72- hour assessment units, because they were non-adherent (defaulted) to taking their medication, they were not considered emergency patients and had to stay until beds were available for their transfer to a psychiatric facility, as a participant mentioned:

“Some of the patients do settle, but then they are defaulters, so they are defaulters on their treatment so doctor, then doctor feel; “no” the patient must stay here and wait for [admission to] hospital X, so that they can be admitted there” (P05).

Decision making regarding the transfer of patients to tertiary hospitals was the responsibility of the medical practitioners treating the MHCUs. However, the participants alluded to the advantage that the admission of patients to district hospitals held for the MHCUs, their families and the communities, as is illustrated by the following excerpt:

“I don’t think the problem is for the patients to be in the district hospital, hmm, because it is better for them and better for the family and everybody” (P01).

However, in order to attain this advantage of being admitted to hospitals near home, the required legislative forms had to be completed to permit the detention of patients in the 72-hour assessment units. A participant also reported on the need to have MHCUs admitted, if their illness warranted further care, treatment and rehabilitation, over a longer period for progress and improvement of their mental health, as alluded to by the participant:

“Yes, because sometimes ... there is a need for them to be institutionalized... and discharging them is not appropriate... because some of them needs long term treatment” (P03).

4.3.1.2. Sub-theme 1.2: Safety measures to exercise social control

Involuntary MHCUs pose potential harm to self, others or property. In addition, when MHCUs present with psychotic symptoms and display extreme behavioural disturbances as well, they need to be admitted to a hospital for containment. Some forms of social control are required to manage the psychotic symptoms, aggressive behaviour and risk of absconding. According to most of the participants, chemical restraints are the first option for managing and controlling MHCUs' untoward behaviour in the district hospitals. The professional nurses in the district hospitals are dependent on psychotropic medication to calm aggressive patients and to protect the staff, other patients and equipment from harm/damage. However prescribed medication was administered even if patients were considered to be “*a bit stable*”, as were revealed by the following participants:

“Some of the patients do get aggressive, but then we try to sedate them for the safety of the staff and for the other patients” (P01).

“Sometimes they're quite psychotic. Some of them are a bit stable, but we try to keep them sedated as prescribed, to prevent them from breaking down our place and injure the next patient” (P06).

Various reasons were given by the participants for sedating MHCUs. These included, calming agitated patients, who repeatedly asked to be released to return home, especially over weekends, when there was less staff, particularly doctors, on duty. Sedation was used in these situations to manage the patients as is reported by the following excerpts of participants:

“So most of the times you do sedate the patients like regularly, so that they just keep calm and be calm, not difficult...they will ask for a doctor all the time, if we don’t sedate, they will ask you; when am I going home “ (P05).

The participants recognised that the presence of security guards and nurses in the 72-hour assessment units enhanced physical control of involuntary MHCUs. In district hospital B, each ward had two security guards, and in district hospital A, each room was staffed with a security guard and a nurse. MHCUs were under constant supervision, both during the day and night. At night, the security guards and nurses observed the MHCUs from their positions in the passages, as asserted by two participants:

“We manage to keep them under supervision, as much as we can... It’s always a security and a nurse...” (P02).

“... at [on] night duty we ... sit in the passage and have to watch them...” (P07).

Whilst seclusion is another form of physical restraint of MHCUs, who display behavioural disturbances and is legislated according to the MHCA (2002), the district hospitals did not have the required infrastructure, in terms of safety. District hospital A had no seclusion facilities, while district hospital B had two seclusion rooms available, however, only in the male ward. The participants cited various reasons for secluding patients, for example, patients who displayed aggressive behaviour, patients who were considered flight risks, or patients who wanted to leave the hospital premises.

According to participants in hospital B, female patients and juvenile/adolescent patients were secluded in the seclusion room at the entrance to the male ward. In the participants’ experience, the female patients and the adolescents were strong and out of control, and often, extra help had to be called in to escort them to the seclusion room, as revealed by the following participants:

“Sometimes you must get the male securities also to help us, because some of them try to abscond. ...and you know some of the female

patients, they are very strong ... they are very strong and you know females, they push and kick everything. So we do get the males to help us at times, but not all the time, if we can handle them, we handle them... Sometimes we do get juveniles, boys that are sixteen years old, fifteen years old and then they have this aggressive outbursts also, then we must sedate this patient now and then you must put him in the seclusion room, just to calm him” (P05).

4.3.2. Theme 2: Patient management challenges in rendering nursing care

This theme focused on the challenges professional nurses experienced whilst working in the 72- hour assessment units. These challenges included the lack of resources to create a therapeutic environment; the lack staff, knowledge and skills and the long periods of hospitalisation of MHCUs as articulated in Table 1.

4.3.2.1. Sub-theme 2.1: Lack of physical resources and noise pollution

The participants reported the limited bed space to accommodate MHCUs at both district hospitals. This was especially true for the male MHCUs, as the wards were over-populated. The lack of physical space to accommodate and care for mentally ill patients in the male ward resulted in MHCUs sleeping on trolleys in overcrowded rooms.

A reason cited by the participants for the limited space was that the 72-hour assessment unit had to be shared with physically ill patients, which resulted in the physically ill patients being nursed together with the mentally ill patients. However, in other instances, the beds were occupied by medical patients, which resulted in fewer beds to accommodate mentally ill patients, as is illustrated by the following excerpts:

“Still the space also, and you know sometimes we find overflow from the medical side, where we have to squeeze in some of the medical patients, which is not conducive for the medical patient as well as the psych patients so” (P02).

“The challenge is there is not enough... beds to accommodate psychiatric patients, because some of the beds have been given to medical patients” (P03).

In addition, the lay-out and inappropriate location of the allocated wards for the 72-hour assessment of MHCUs, impeded the rendering of effective and efficient nursing care to the patients. In hospital A, the designated rooms were situated in close proximity to the casualty department, and the corridor linking the casualty department to the rest of the hospital. The entrance doors to the 72-hour assessment rooms faced the passage, which was utilised as a thoroughfare to the medical ward and the rest of the hospital. This was a very demanding area with high noise, as there was a constant stream of patients passing through, as is illustrated by the following excerpt:

“...the passage, the corridors they share with other patients. Other patients do make interruptions, because they are passing within the corridors, so there is noise, it’s not a quiet environment at all” (P03).

Consequently, the MHCUs were continually exposed to noise pollution from fellow-patients, the constant movement of people, trolleys and equipment in the passage, together with the public address system, telephones that were ringing and people talking. This caused the MHCUs to become more unsettled and confused. This situation was perceived by the participants as being non-therapeutic, as reported by one participant:

“... this is everybody’s passage, it really confuses them, because people that are going to pharmacy, people that are going to X-rays, people that are going to the wards, it’s... never ideal for them” (P02).

In order to manage the non-therapeutic environment in a situation over which they had little control, the participants reported that they resorted to sedating the agitated MHCUs to calm them. However, the sedation was perceived to be less effective because of the persistent noise, as reported by one participant:

“You will find the [people] outside is making such row [noise] and it affects them [MHCUs], but what can we do?...here’s no silence...even if that patient ... is going to be sedated, because of the

noise and everything, it takes long to work and even to calm him down... because of the noise” (P02).

In addition, the physical layout of the ward, which was characterised by limited space, did not favour the conducting of therapeutic interventions. In hospital B, gates that served as boundaries to contain patients, were perceived as non-therapeutic and participants reported:

“... to look at gates so it really feels, I can imagine, it feels like an animal in a cage” (P008), which allowed only limited mental health nursing care.

In hospital A, all the male MHCUs were in one room and the female MHCUs in a separate room within the medical ward. Consequently, all interventions and communication in the room were seen and heard by the fellow-patients, the nurse and the security guard, with nursing staff resorting to render only basic care, as one participant said:

“There is no space for group therapy or any kind of intervention, because of the space. There are only the two rooms and that’s it. The staff can only come around, doing the basics” (P01).

4.3.2.2. Sub-theme 2.2: Lack of nursing staff, knowledge and skills

There was a staff shortage in the 72-hour assessment units, with only three nursing personnel caring for up to 18 patients at a time. The MHCUs’ behaviour was deemed unpredictable, and, therefore, required constant supervision from staff on duty. The workload increased, and responsibility of the participants increased further, when staff had to escort patients, who were being transferred to psychiatric hospitals. Furthermore, the participants referred to the responsibility of caring for the patients over weekends, as doctors were only available for emergencies, as one participant reported:

“... there’s no doctors over week-ends; we only phone the doctor when there’s an emergency” (P05).

The 72-hour assessment units staffing was perceived as be unstable, as nursing and medical staff were rotated. There was no doctor allocated permanently to the

unit for a period of time. The participants reported that it became their duty, as well, to orientate the doctors to the ward, when they were rotated, as the following participants asserted:

“Every month, they use to give me another doctor ...just get them up to standard, that they know exactly what to do, then the next one comes...” (P01).

“There were staff employed for psychiatry and we thought that we are going to focus on them, but eventually they were rotated in the hospital” (P04).

In addition, participants described the challenges of working with untrained security personnel, who were to ensure the patients’ and others safety. These security personnel did not have the skills to manage the behaviour of the MHCUs, as a participant reported:

“What is challenging now for us, the security that work there, they’re not trained...some of them never worked with patients and that make it difficult” (P06).

As the security personnel were not trained and skilled to manage the aggressive and violent behaviours of the MHCUs, they were often assaulted by the patients. The participants displayed some empathy towards the security, when they were assaulted, as one participant expressed:

“They do get quite physical towards the security. Shame the poor securities, they also get assaulted. Yes shame, they do” (P07).

While the necessary skills were important to manage the behaviour of the MHCUs, knowledge about the MHCA (2002) is necessary to effect the proper admission process of MHCUs, who are deemed a danger to themselves and others. According to the MHCA (2002), specific forms/regulations must be completed accurately to effect the admission. These forms are completed by various role-players throughout the admission process. The participants alluded to their experience of MHCUs, who arrived at the district hospital without the necessary documentation, or incomplete forms. This resulted in the participants having to redo the documentation, or to attempt at contacting the family members and/or the referring institutions to rectify the forms. This exercise was perceived

as time consuming. Many participants expressed their frustration with the amount of administrative work the completion of incomplete forms entailed, which prevented them from rendering patient care. This increased their workload, as illustrated by the following excerpts:

“Some of the people think this ward is not busy, but we are very busy, you know, because of the forms, me, I’m alone here, I must check the forms, and we must check the patients and we must give sedation in-between. I must phone if their form, if the forms are incorrect from the other institutions, then we must send the forms back to them and then...” (P05).

“... there’s a problem, because I feel I cannot be with my patient, because there are too many forms that must be ready, that must be rectified... there is really no time for my patients because it’s more administration” (P08).

4.3.2.3. Sub-theme 2.3: Long periods of hospitalisation

According to the MHCA (2002), involuntary MHCUs should be transferred for further care, treatment and rehabilitation services, after the completion of the 72-hour assessment period. The participants in both district hospitals reported that, on occasion, the MHCUs stayed in the 72-hour facility for long periods of time, which could be more than a month, due to the lack of beds at the psychiatric hospitals. The long waiting lists were perceived to be a “farce”, as they were ineffective, which created a bottle-neck, with the participants alluding to themselves as being “stuck” with patients, who were waiting to be transferred, as illustrated by the following participants:

“There’s always no place at [hospital X], because of the big drainage area, and hmm due to that, you keep the patients longer” (P01).

“Sometimes they have to go on the waiting list after even if they’ve been here for a month ...So this thing of a waiting list is a farce...So we get stuck with the patients most of the time” (P04).

The long waiting lists resulted in MHCUs having to receive continued care in the 72-hour facility, although they required specialised interventions. A participant

described the MHCUs, who were awaiting transfer, as being kept “*waiting and waiting*”. Additionally, a participant described her sense of helplessness at the limited mental healthcare that patients were receiving, while waiting to be transferred to the tertiary hospitals, as depicted in the following quotations:

“I feel, in a sense, helpless, because sometimes I can see the patient’s medication is being adjusted, but he is not getting better, then it feels like really, what are we doing wrong for this patient? Doctor has increased the medication and but still the patient is getting worse and sometimes the patient...is really not getting better and the patient has been there for more than 2 months...” (P07).

“You know...sometimes you get frustrated you know, because this patient stays here and they do not settle some of them, do not settle on their medication” (P05).

The long waiting lists lead to increased pressure for beds in the 72-hour facility, which results in MHCUs being discharged prematurely, even though the participants believed that they still required care and treatment. The participants were of the opinion that the patients were not receiving the care they required and expressed their displeasure at the current situation.

4.3.3. Theme 3: Burden of caring on the Self

This theme focused on the emotional effects that the participants experienced working in the 72-hour assessment units, as well as the effects that the stigma related to working with mentally ill people had on them and their patients.

4.3.3.1. Sub-theme 3.1: Emotional strain on the Self

The participants described the emotional effects they suffered while caring for a diverse patient population that was admitted to the 72-hour assessment unit. They reported on how frustrating their work environment was, which they had no control over. Mentally ill and physically ill patients were accommodated together in the wards. In addition, different legal categories of MHCUs, namely voluntary, assisted and involuntary, ranging from adolescents to geriatric patients, were nursed together. Furthermore, the MHCUs interfered with medical (physically ill) patients’ treatments. The participant’s workload was increased, as they had to

restore order to the chaos, by providing constant supervision to deter patients from displaying untoward behaviour, as the following participants reported:

“When there is a medical patient admitted here maybe this patient is on ...IV treatment like a Ringers...then some of the patients ...they will scratch everywhere and ...they will like stand there with this patient the whole time and ...they will fiddle with the drips or something...the suicidal patients that we do admit here and it’s also very challenging, because... we have to monitor that room continuously, ... so it’s very challenging for us as personnel, as professional nurses if there is a medical patient admitted here” (P05).

“If we have enough beds and we didn’t receive any psychiatric patients, then we still have empty beds, ... then they will push some of the other patients into our two rooms, which is not, which is not ideal, because then they put in surgical patients or medical patients or orthopaedic or gyne [gynaecology] or, whatever...it is definitely not ideal” (P01).

Caring for male and female MHCUs, in addition to patients with cognitive disorders, was also challenging. In hospital B, the females were secluded in the male ward, and the male adolescents were nursed in a single room, in the female ward. This situation was perceived to be challenging, as nursing interventions had to be planned accordingly, to fit the MHCUs diagnoses, as is referred to in the following quotations:

“The challenges, especially the old patients that come in, the dementia patients, they lie between the psychotic patients. Now you have to treat them in a different way, but yet you must be fair” (P06)

“... Ja [yes], it is, a very big challenging, because some of them, you know, when you bring the females from that side [to the male side]...We have to put something here to cover because some of the female patients, they do undress them self and you know how men are, you know how psych men are. They all stand here to see and watch what going on in front” (P05).

The participants were further frustrated when the MHCUs basic human rights were violated, as females did not have a private place to undress, with male patients observing their state of undress. The participants attempted to remedy the situation with little success, which increased their frustration. In addition, the participants started questioning themselves, and doubting their professional abilities to render mental health care to MHCUs. A participant communicated an incident that occurred five years before, but did not give the specifics, as it was too painful to mention. She later said “... *I felt like I failed the patient*”. Another participant reported feeling “*helpless*”, when, despite giving MHCUs their medication, their mental illness did not improve, as is illustrated by the following excerpts:

“I feel, in a sense helpless, because sometimes I can see the patient’s medication is being adjusted, but he is not getting better, then it feels like really, what are we doing wrong for this patient...” (P07).

“...Did I do my best? Where did I fail my patient and what can I do best for the next patient?” (P05).

All the participants described the emotional turmoil they experienced while working in the 72-hour assessment units, which was fraught with questions that remained unanswered.

4.3.3.2. Sub-theme 3.2: Stigma related to mental illness

The stigma related to mental illness, whether an individual works with MHCUs, or was a MHCU, was pervasive in the selected district hospitals. The participants verbalised that they were stigmatised for merely working with mentally ill patients, or they were aware that staff working in the 72-hour units were being stigmatised. Their physical gait was likened to “*the staff is walking like the patients*”. The participants also reported that the length of time they had worked with MHCUs, resulted in them being perceived as being “*one of them*” (P006) by their colleagues. Another participant mentioned that when they [participants] made errors, their behaviour was ascribed as being consistent with the ward they worked in, which, in this case, was described as “*you’re from that crazy ward*” (P07).

Given that they themselves were stigmatised, one participant reported that she was not an advocate for her patients, as is illustrated below:

“I feel I don’t advocate for my patient, truly, that’s how I feel” (P08).

This was especially true when a MHCU was admitted to Hospital B with diarrhoea, but because she had a mental illness of schizophrenia, the staff focused on the mental illness whilst ignoring her physical symptoms as is illustrated by the following excerpt:

“We recently had a patient... familiar with a history of schizophrenia... known with diabetes and hypertension... she came in, was [with] diarrhoea... So for me it was, the whole time they looked at her background of schizophrenia... did not sort the medical part out...if it was only a psychiatric ward, then we’ll understand...” (P08).

The participants further alluded to MHCUs being further stigmatised by their families because of their mental illness.

4.3.4. Theme 4: Staff and patient support to create a therapeutic environment

This theme focuses on the support that staff needed to create a therapeutic clinical environment, which included staff retention and development, in addition to the provision of physical and therapeutic resources that both staff and MHCUs required to assist in the provision of mental health care in the 72-hour assessment units.

4.3.4.1. Sub-theme 4.1: Staff retention and development

Staff retention is important to ensure the effective functioning of the 72-hour assessment unit. More nursing staff and, in addition, less rotation of staff, to ensure stability, in terms of the staff who worked in the 72-hour assessment units, was required. The participants felt that this could be achieved by the allocation of permanent nursing staff members, as well as medical personnel, namely doctors. Patient outcomes would be improved as there would be continuity of patient care and trained nursing staff would be able to assess patients, as the following participants stated:

“Because, the patients’ need stability and if staff is the only stability that we can actually provide, then at least we get somewhere, because if you, you can’t do anything to...the infra-structure, but at least ...

they can provide us with specific staff and that also makes the patients more comfortable, because at least it's not every day they see somebody else. So there's more continuation of services rendered to the patients" (P01).

"... If there is more of the staff then I will be able to sit also with the assessments" (P02).

In addition, the patient population admitted to the 72-hour units were diverse, in terms of the MHCA (2002), therefore, their nursing needs were different. The participants alluded to the need for adequate staff to manage this diverse patient population.

The participants also identified the need of formal in-service training for security staff, as well as the lower categories of nursing staff, which were not trained in managing patients with mental illness. As communication among staff is important when rendering care to MHCUs, the participants asserted that the nursing staffs, who nurse the MHCUs, must be included in decision making, namely ward rounds, where patient management was discussed. In addition, the participants articulated the need to be included in communication with various stakeholders, who were involved in decision making around the MHCUs' management, as is expressed by the following quotation:

"The way forward is communication has to [be] with the management, to find a way out, how to deal with the therapeutic environment, management of psychiatric patients, 72-hour assessments and also have the meetings with the management, the doctors where we will be able to say our fears" (P03).

4.3.4.2. Sub-theme 4.2: Provision of physical and therapeutic resources

In order for MHCUs to receive care, treatment and rehabilitation, a therapeutic environment is required. The participants expressed the need to care for MHCUs in an attractive environment, which promoted mental well-being, as well as a safe place, where MHCUs could become well. In addition, the participants suggested the initiation of therapeutic programmes to improve patient outcomes and alleviate boredom, as expressed in the following excerpts:

“To be [an] open ward, not this [these] cubicles. An open ward with a dining room, nice chairs, nice colourful curtains, music, TV’s, games etc.” (P06).

“More activities for them to do, more activities. Some of them are getting very bored and some of them also get frustrated, because there’s nothing to do for them, to keep them busy that’s why they are, some of them become aggressive and wanted to go home and stuff like that” (P004).

The admission of a combination of medical and psychiatric patients in the 72-hour assessment unit, was demanding and the participants expressed the need to treat and care for the MHCUs in a separate ward, as they believed separate facilities would improve patient outcomes, as reported:

“I would like them to be separate from the medical patients and I would like them to have beds and a little bit more, a safe space ... I would like, them to have the same nurses, yes”. (P08).

4.4. Discussion of the findings

A discussion of the findings relating to the four themes that emerged during the data analysis process of this current research study is discussed in the following sections.

4.4.1. Theme 1: Patient management process affected the functioning of the unit

This theme explored the management of patients in 72-hour assessment units at the two district hospitals under study, as well as how it affected the functioning of the unit. Most of the participants responded positively to the global initiative of integrating mental health care into primary health care. The integration of mental health care into the general health services, promoted by the MHCA (2002) and the Mental Health Policy Guidelines (SA DoH, 2010a), improves access to the health system for the entire population by making primary health care the first contact in the health system and ensuring the development of community-based services.

4.4.1.1. Sub-theme 1.1: Referral pathway of involuntary MHCUs

The participants stated that in the referral pathway, the primary health care clinic is the port of entry into the public health service, with the district hospital the next step, should hospitalisation be required. The patients in this study were admitted in the Emergency Department of the district hospital, after being referred from the primary health care clinic (SA WC DoH, 2009). The participants revealed that there was an influx of patients and the district hospitals did not have control over the number of involuntary MHCUs arriving at the Emergency Department, due to the burden of mental illness. The incidence of mental illness is exacerbated by substance abuse, as was confirmed in a study by Herman *et al.* (2012), predicting that 30% of adults in the Western Cape Province will develop a mental disorder in their life-time.

The observation and assessment of involuntary MHCUs in the district hospitals form part of the process of care, treatment and rehabilitation, as stipulated by the MHCA (2002). In accordance with the MHCA (2002), beds are dedicated in district hospitals to provide 72-hour admission and observation services to MHCUs (Petersen *et al.*, 2009). Internal transfers of patients' are made from the emergency department to the 72-hour facility. Some participants mentioned that the transfer from the emergency department was prioritised, as the involuntary MHCUs behaviour necessitated speedy transfers, which is supported by the findings of Chakravarthy *et al.* (2011), who state that psychiatric clients in the Emergency Department are loud and their stay is long and chaotic.

The 72-hour assessments of MHCUs are conducted in designated wards, or rooms, in the district hospitals. In hospital A, two rooms, originally one four-bed and one six-bed room were converted by removing the curtain screens around the beds and replacing the beds with trolley beds. These two rooms, situated within the medical ward, accommodate the involuntary MHCUs and serves as the 72-hour assessment unit. In hospital B, the MHCUs were initially admitted in the general medical ward, but recently two wards, one for males and one for females were allocated for MHCUs.

The 72-hour assessment of involuntary MHCUs is provided in the district hospitals with subsequent provision of further involuntary care treatment and rehabilitation in psychiatric hospitals (SA DoH, 2002; 2012). External transfers take place between the district hospitals and level 1, 2 or 3 hospitals. The patients' unmanageable behaviour, lack of improvement to treatment, and non-adherence to treatment were motivators for external transfers. Involuntary MHCUs in this study presented with the same symptoms, as revealed in a study by Hanssen-Bauer *et al.* (2011), describing that adolescents and adults are subjected to compulsory admission, when they present with psychotic conditions, hyperactivity, violence, hallucinations, delusions, emotional problems and pose a considerable risk to themselves or others. The participants confirmed that the involuntary MHCUs, who presented with extreme unpredictable behavioural problems, were difficult to manage in the district hospital. This was also reported in a study by Ramlall *et al.* (2010), who reveals that managing disruptive patients in a general ward setting could be challenging. As hospital A does not have seclusion facilities, patients who posed a threat, could be transferred to another district hospital, with special permission.

The participants acknowledged that the functioning of district hospitals was to the advantage of the patients and their families, as the prospect of being treated close to their place of residence, as noted by the WHO and Wonca (2008), was an improvement in service delivery. Ramlall *et al.* (2010) states that a number of people with severe mental disorders will require hospitalization at some point in their lives and because district general hospitals are situated in accessible and acceptable locations, the expectation is that district hospitals should provide a full package of care to patients.

4.4.1.2. Sub-theme 1.2: Safety measures to exercise social control

According to Gray and Smith (2009), social control refers to the managing of aggressive patients, referred to as restraint. Chemical restraints were mostly used to control the aggressive behaviour and psychotic symptoms of MHCUs. The participants used social control to manage and contain the mentally ill patients in the 72-hour units, and ensure the safety of other patients, staff and property. Involuntary MHCUs, refuse health interventions, but require such services for

their own protection, or for the protection of others (Uys & Middleton, 2014). The participants in this study stated that they used sedation and anti-psychotic medicine on a regular basis, and at certain times, during peak periods and over week-ends, when there is no doctor available, to maintain the smooth running of the ward.

Physical control was exercised through the visibility and presence of the security and by the nurses in the 72-hour units. The participants valued the presence of security personnel in the 72-hour units to help with constant supervision of the patients requiring physical control. This was affirmed in a study by Petska *et al.* (2012), reporting that the security officers' help to de-escalate a situation, as well as provide hands-on assistance, and that, just the presence of officers in uniform, could at times help to calm the situation. Another form of physical control is seclusion. Hospital A had no seclusion facilities and hospital B had two seclusion rooms in the male ward. The seclusion room at the entrance to the male ward was used, occasionally, for female and adolescent patients, to control their violent behaviour.

4.4.2. Theme 2: Patient management challenges in rendering nursing care

This theme focused on the challenges professional nurses experienced while rendering nursing care in the 72-hour assessment units. The participants accepted the fact, as part of the integration of mental health care into primary health services, that involuntary MHCUs have to be admitted to the district hospitals initially, but were candid about the challenges they experienced in the 72-hour facility. The MHCA (2002) was promulgated nearly 12 years ago and although some changes were made to accommodate the MHCUs in the district hospitals, participants reported the huge service delivery and resource gaps. The professional nurses experienced the lack of resources to create a therapeutic environment, the lack of knowledge and skills, the patients' long periods of hospitalisation, the stigma attached to mental illness and the burden of caring for a diverse patient population, as very challenging.

4.4.2.1. Sub-theme 2.1: Lack of physical resources and noise pollution

The two district hospitals under study had designated rooms, or wards, to accommodate involuntary MHCUs. The participants in hospital A alluded to the

frequent overpopulation (overcrowding) of the male ward, with patients having to sleep on mattresses on the floor. A survey conducted in district hospitals in KwaZulu-Natal by Ramlall *et al.* (2010, pp. 668) reveal that 63.9% of hospitals reported a lack of appropriate and adequate facilities, to provide psychiatric services as required by the MHCA (2002), which included seclusion facilities, sufficient beds, as well as trained medical and nursing staff. Petersen *et al.* (2009; 2011), Lund *et al.* (2009), and Janse van Rensburg (2010) concur that both human resources and infrastructure across provinces in South Africa need to be improved. This concurs with comments from this study's participants on the outlay and the inappropriate location of the wards, as well as the lack of physical space in the units. Noise pollution, the constant interchanging of people, the lack of physical facilities and resources, contributed to an unsafe and non-therapeutic environment that all the participants regarded as impeding on effective nursing care. The participants in hospital A were unanimous in their criticism of the constant noise, the overcrowding and the unruly environment, which unsettled patients even more. This is consistent with studies conducted by Chakravarty *et al.* (2013), Korn, Currier and Henderson (2000); Santiago, Tunik, Foltin & Mojica (2006), reporting that psychiatric patients' hospitalisations were loud, long and chaotic, resulting in an unhealthy environment and a high incidence of symptom escalation.

The participants' frustration with the lack of physical facilities, which they opined, hampered therapeutic interventions, were also reported on in a study by Janse van Rensburg (2010), stating that only the most essential nursing tasks were performed, which left nurses with inadequate time for individual case management, group therapy, health education or attending ward rounds.

4.4.2.2. Sub-theme 2.2: Lack of staff, knowledge and skills

According to the participants in this study, the constant shortage of staff was exacerbated by the continuous rotation of nurses and doctors, and increased even further when nurses from the ward had to escort MHCUs, who were being transferred to psychiatric hospitals. This increased the workload and responsibility of the remaining professional nurses in the ward, as they had to execute their professional duties, perform the nurse's duties and take

responsibility for some of the doctors' duties. Janse van Rensburg (2010) reported that nursing ratios in the 72-hour units were below the WHO norm, with nursing staff having to carry the load of 2 to 3 workers at any given time. Hospital A recently implemented consistency of nursing and other staff in the 72-hour unit by curbing the continuous rotation of staff, to create more stability for the patients, as well. In a study conducted by Janse van Rensburg (2010), staff rotation was perceived as having a negative impact on nursing care rendered to patients, as the staff had limited knowledge and lacked expertise in the field.

The participants in this current study also alluded to the lack of knowledge of all categories of staff working in the 72-hour unit, which concurs with studies conducted by Sharrock & Happell (2006) and Happell (2008), referring to the nurses not being adequately prepared, and lacking the necessary skills, as well as experience to care for patients with mental problems. The security guards in the two district hospitals under study were also prone to being attacked by the MHCUs, as the participants expressed their empathy toward them for being the victims of assault. According to the participants in this study, the lack of knowledge and skills of staff working in the 72-hour units could almost apply to all the staff, as most of the doctors, nursing staff and securities did not have the expertise and/or specialised qualification to manage acute MHCUs with complicated diagnostic criteria.

According to the MHCA (2002), the involuntary admission of MHCUs has to follow a statutory procedure, which includes the completion of specific forms, to effect the admission. These forms are completed by the various role-players throughout the admission process. The participants were familiar with the Regulations of the Mental Health Care Act (2002), which stipulated the admission process and the regulatory MHCA forms. In this study, the participants reported that often the forms were incomplete, or incorrect, when patients arrived at the district hospital, compelling them to either redo the forms, or try to contact the family and/or referring institution, which mostly led to futile attempts. The participants expressed that this further increased their workload, which affected the quality of nursing care. The findings of the current study are consistent with a previous study conducted by Ramlall *et al.* (2010), in which concerns were raised

regarding the administrative burden and paperwork surrounding involuntary admission and the 72-hour assessment process.

4.4.2.3. Sub-theme 2.3: Long period of hospitalisation

Despite the MHCA (2002), stipulating that involuntary MHCUs should be transferred to psychiatric hospitals after the completion and findings of the 72-hour assessment period, the lack of beds caused most of the patients to stay in the district hospitals for longer periods. The participants reacted with a sense of helplessness, as patients requiring specialised care were contained in the 72-hour facility because of the long waiting lists at the psychiatric hospital. A study conducted by Janse van Rensburg (2010) reveals that the average length of stay (LOS) in acute general district hospitals in Johannesburg was three weeks. In this current study, the participants reported that some patients were discharged prematurely, although they still needed care, treatment and rehabilitation. Although the participants reacted with frustration about the MHCUs' lengthy stay in the district hospitals, they felt a sense of helplessness with the limited mental health care the patients received in the district hospital, which was exacerbated by patients being discharged prematurely.

4.4.3. Theme 3: Burden of caring on the Self

The diverse diagnosis and mixed profile of the patients in the 72-hour assessment unit were experienced as challenging for professional nurses. Mentally ill patients (three different legal categories of MHCUs, for example, voluntary, assisted and involuntary), as well as physically ill patients, were accommodated together. Added to this were the huge differences in age, diagnostic criteria and, at times, even gender differences. Studies conducted by Seed, Torkelson and Alnatour (2010) and Cleary (2003), acknowledged that the role of the acute care psychiatric nurse is demanding and complex, because there is an expectation to provide a safe, structured, and supportive environment for a diverse mix of patients.

4.4.3.1. Sub-theme 3.1: Experience of emotional strain

While working in the 72-hour assessment units, negative incidents caused the participants to doubt their professional capabilities, as they felt that they had failed their patients, because of their unsuccessful mediation, or advocating

efforts. Burns (2008) reported on the problems encountered in managing 72-hour MHCUs in district hospitals, highlighting that most facilities encountered serious problems, which led to the delivery of sub-optimal levels of care and occasional disasters. The participants in this study shared some adverse or critical incidents that they had experienced, which impacted negatively on the well-being of the patients. They reacted by emotionally expressing feelings of helplessness, of not advocating for my patient and of being a failure. The participants perceived the critical incidents as a negative reflection on their professional role.

4.4.3.2. Sub-theme 3.2: Stigma related to mental illness

It is a reality that MHCUs are being stigmatised or despised, which is supported in a study conducted by Ross and Goldner (2009), confirming that nurses' negative attitude towards psychiatric patients was borne out of the stigma and discrimination associated with mental illness. A survey by Ramlall *et al.* (2010) revealed that one of the triumphs of the integration of mental health into primary, or general health, was the reduction of stigma. A study conducted by Petersen *et al.* (2011) on mental health service delivery in South Africa identified stigma and discrimination as shortfalls. A participant in that study described her experiences of being a victim of stigmatisation, merely because she worked with mentally ill patients. The participants in this current study reported on family members and staff that stigmatised the patients. A study conducted by Reed and Fitzgerald (2005) highlight three factors that influence nurses' negative attitude towards MHCUs as, the unavailability of specialised mental health services, the assumed aggressiveness of psychiatric patients, and the lack of knowledge to manage them. A study conducted by Petersen *et al.* (2009) argued that staff shortages and the fact that psychiatric patients were being cared for by nurses with varying degrees of experience in mental health, were connected to stigma.

4.4.4. Theme 4: Staff and patient support to create a therapeutic environment

Participants at the selected district hospitals articulated the need for staffing resources that included development of staff, in addition to formal training for security personal and lower categories of staff, which were not skilled in caring for people with mental illnesses. In addition, physical resources, such as adequate space to care for patients,

would also allow therapeutic programmes to be implemented, given that there would be space to conduct the programmes.

4.4.4.1. Sub-theme 4.1: Staff retention and development

The need to retain staff in the 72-hour unit was articulated by all the participants in this study. Permanency of staff, especially medical doctors, was equated to less work, as the participants would no longer need to orientate new doctors to the 72-hour unit. In addition, patient outcomes would improve, as there would be continuity of patient care.

Staff development that would focus on skills training for security, who worked in the 72-hour units, was identified as a need. The skills identified, focused on the management of aggressive patients. Given that involuntary MHCUs pose a danger to themselves and others, it would be pertinent that the security personnel, who were tasked with exercising social control, would have the necessary knowledge and skills to protect all the MHCUs, unit staff and themselves. Lower categories of staff also worked in the 72-hour assessment units. These nurses' training is focused on rendering basic nursing care, therefore, unless they had worked with MHCUs previously, they would not have the necessary knowledge and skills to manage involuntary MHCUs, much less patients, who were admitted with various mental health diagnosis, such a suicidality.

Communication was also identified by the participants as important for the rendering of effective nursing care to MHCUs, who were admitted to the 72-hour assessment units. Participants articulated the need to be included in ward rounds, where patient management was discussed, as they were the MHCUs' primary care givers and were conversant with important patient information.

4.4.4.2. Sub-theme 4.2: Provision of physical and therapeutic resources

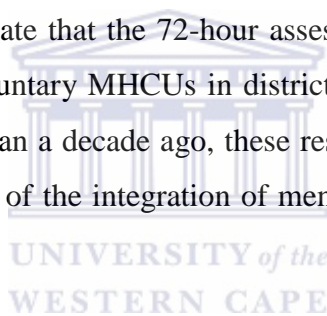
A therapeutic environment is required to ensure that the MHCUs receive optimal care, treatment and rehabilitation in the least restrictive environment possible. Participants alluded to the need to have an attractive, safe physical environment, where patients received care, including the provision of therapeutic programmes that would ensure the recovery process. This was supported in a study conducted

by Quinn, Happell and Browne (2011) at the Royal Melbourne Hospital, where patient outcomes increased when a better standard of care was provided, in a more appropriate and therapeutic environment.

The participants also mentioned that the physically ill and mentally ill patients would benefit from retaining nurses in separate facilities, as their nursing needs were different. Given that mental health care is specialised care, provided by a multi-disciplinary team that possesses specialised knowledge and skills, this need is warranted.

4.5. Conclusion

The four major themes and nine sub-themes, which articulated the experiences of professional nurses working in the 72-hour assessment units at two selected district hospitals, were presented. The results indicate that the 72-hour assessment units were non-therapeutic and ill prepared to manage involuntary MHCUs in district hospitals. Given that the MHCA (2002) was implemented more than a decade ago, these results allude to very slow progress, if any at all, in realising the goal of the integration of mental health care into general health care.



Chapter Five incorporates the conclusions, limitations and recommendations of this study.

CHAPTER FIVE

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1. Introduction

The major themes were identified and the research findings were discussed in the previous chapter with verbatim quotations from the interviews to support the findings. This chapter covers the attainment of the objectives of the study, by way of conclusions. The limitations, strengths and recommendations, based on the findings of this study, will also be discussed.

5.2. Conclusions

This study explored the lived experiences of professional nurses working in 72-hour assessment units at two district hospitals in the Western Cape metropole region. In order to determine the experiences, the following three objectives were formulated and met in this study.

5.2.1. Objective 1: To determine the functioning of the 72-hour unit within the district hospital.

The patient management process affected the functioning of the 72-hour assessment units. The participants alluded to the onerous task of referrals and transfers of involuntary MHCUs, from the primary health care centres, to district hospitals, and again on to the tertiary hospitals, when the patient's health condition/s warranted it. As part of the integration of mental health into primary health care delivery, involuntary MHCUs are admitted to district hospitals. Chemical and physical restraints are applied to exercise social control in a non-therapeutic environment.

5.2.2. Objective 2: To explore the experiences of professional nurses with regard to the integration of the 72-hour assessment units, within the district hospital

The integration of the 72-hour assessment unit into the district hospital is fraught with challenges, such as, lack of physical resources, noise pollution, staff shortages, lack of knowledge and skills, in addition to the long periods of hospitalisation that MHCUs experienced due to the lack of facilities for transfers. These challenges affected both the

participants and the MHCUs they cared for. The well-being of MHCUs was prioritised by the participants, who mostly externalised their own experiences. However, by delving deeper, a few participants articulated the emotional burden they experienced, which negatively affected their ability to render proper patient care, as they questioned their professional abilities. The non-therapeutic environment created by having a diverse patient population was perceived as containment of patients, rather than the rendering of care, treatment and rehabilitation to MHCUs.

5.2.3. Objective 3: To determine the suggested improvements within the district hospitals in order to accommodate the 72-hour assessment units.

The participants alluded to efforts that promote staff retention and the development of staff, which focused on the education and training of staff working with mentally ill patients in 72-hour units in the district hospitals. Support was still required, in terms of adequate physical resources and therapeutic programmes, in addition to the allocation of optimum resources, to ensure that patients receive safe, quality mental health care in the least restrictive therapeutic environment.

In conclusion, the MHCA (2002) was promulgated in 2002, and the implementation thereof occurred on 15 December 2004. Given that this legislative process occurred more a decade ago, the findings of this study confirmed, similar to other researchers, that numerous factors have impeded the implementation thereof. In addition, the WHO has promoted the integration of mental health care into primary health care, more than five decades ago, however, slow progress (if any) is observed despite these policy imperatives.

5.3. Limitations of this study

- This research study was conducted in two district hospitals in the Western Cape. The sample size was purposefully selected and comprised of professional nurses working in the 72-hour assessment units. The experiences of professional nurses from only two district hospitals were contextualised in this study, therefore, the findings cannot be generalised.
- Participants shared their experience at a single point in time; however, it is possible that the participants' perceptions could have been modified later.

- The continuous disruptions and noise experienced during some of the interview sessions negatively affected the flow and consistency of the participants sharing their experiences.

5.4. Strengths of the study

The phenomenological approach used in the study is its strength. This approach gave participants a vehicle to describe, in their own words, their own experiences of nursing psychiatric patients in a district hospital. Their stories gave the researcher an overview of their day-to-day experiences in the 72-hour assessment units.

5.5. Recommendations

The recommendations for this study are for future research, practice and nursing education.

5.5.1. Recommendations for future research

- This current study will serve as a base for future studies. It would also be beneficial if similar studies, or if this study could be replicated in other district hospitals, in order to ascertain whether the implementation of the MHCA (2002) regarding 72-hour assessments have been realised.
- A systematic review, to ascertain best practice elements for the integration of 72-hour assessments into general hospitals, needs to be conducted.
- Quantitative studies/surveys should be conducted to ascertain the factors that promote the integration of mental ill patients into general hospitals.

5.5.2. Recommendations for practice

- A therapeutic environment with all the necessary infrastructure and resources is required to ensure that mentally ill patients receive care, treatment and rehabilitation in the district hospitals.
- Management should ensure adequate and skilled staff are deployed to work in the 72-hour assessment units.
- Designated committed, psychiatric staff should be employed to ensure consistency in patient care.

5.5.3. Recommendations for nursing education

- In-service training on the management of psychiatric patients should be offered to security personnel working in the 72-hour assessment units.
- Training and education of personnel should focus on specific behavioural management of aggression and violence.
- Stigma about mental illness should be addressed through in-service training, workshops and outreach projects of all staff, working in the district hospitals.

5.6. Conclusion

In this chapter, the conclusion of the study highlighted how the research objectives were attained through a rigorous, descriptive phenomenological research design and methodology. The limitations of the study, in addition to recommendations for future research practice and education were also discussed.



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APPENDICES

APPENDIX A: Ethics clearance letter (UWC)



OFFICE OF THE DEAN
DEPARTMENT OF RESEARCH DEVELOPMENT

11 July 2014

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape approved the methodology and ethics of the following research project by:
Mrs V Van Zyl (School of Nursing)

Research Project: The experiences of professional nurses working in district hospitals in the Western Cape Metropole where 72-hour assessments are conducted

Registration no: 14/5/28

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

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



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

APPENDIX B: Application to Health Research Council

13 Van Bruggen Ave

Hoheizen

Bellville

7530

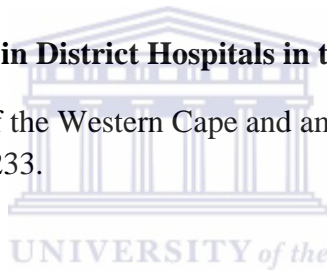
Assistant Director: Health Research
Directorate: Health Impact Assessment
Department of Health
Cape Town
8000

2014 January 23, 2017

Dear Ms Charlene Roderick,

Permission to conduct research in District Hospitals in the Western Cape Metropole

I am a student at the University of the Western Cape and am busy with my Masters in Nursing. My student no. is 3312233.



I hereby request permission to collect data from professional nurses working in the 72-hour assessment units in District Hospitals in the Western Cape Metropole for the following research project:

The experiences of professional nurses working in district hospitals in the Western Cape Metropole where 72-hour assessments are conducted.

The project has been approved by the Senate, Research Ethics Committee of the University of the Western Cape.

Registration no: 14/5/28

Yours sincerely

A handwritten signature in cursive script, appearing to read "Verna van Zyl".

Verna van Zyl (Mrs)

APPENDIX C: Permission letter from Western Cape Government



Western Cape
Government

Health

STRATEGY & HEALTH SUPPORT

Health.Research@westerncape.gov.za
tel: +27 21 453 8857; fax: +27 21 453 8870
5th Floor, Nelson Rose House, 8 Robbeek Street, Cape Town, 8001
www.westerncape.gov.za

REFERENCE: WC_2015RP58_696
ENQUIRIES: Ms Charlene Roderick

Robert Sobukwe Rd, Bellville
Cape Town
7635

For attention: **Mrs Vema van Zyl**

Re: THE EXPERIENCES OF PROFESSIONAL NURSES WORKING IN 72-HOUR ASSESSMENT UNITS WITHIN A GENERAL WARD IN A DISTRICT HOSPITAL IN WESTERN CAPE.

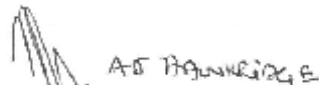
Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research. Please contact the following people to assist you with any further enquiries in accessing the following sites:

Helderberg Hospital W Viljoen Contact No: 021 902 8036

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities of requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (annexure 9) within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
3. The reference number above should be quoted in all future correspondence.

Yours sincerely



DR A HAWKRIDGE
DIRECTOR: HEALTH IMPACT ASSESSMENT

DATE: 26/8/2015
CC: M PHILLIPS

DIRECTOR: KHAYELITSHA/ EASTERN

APPENDIX D: Permission letter from Western Cape Government



STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
Tel: +27 21 483 4657; Fax: +27 21 483 5095
2nd Floor, Nordan Road, (opp.) S Robson Street, Cape Town, 8001
www.westerncape.gov.za

REFERENCE: WC_2015RP58_696
ENQUIRIES: Ms Charlene Roderick

**Robert Sobukwe Rd, Bellville
Cape Town
7535**

For attention: **Mrs Verna van Zyl**

Re: THE EXPERIENCES OF PROFESSIONAL NURSES WORKING IN 72-HOUR ASSESSMENT UNITS WITHIN A GENERAL WARD IN A DISTRICT HOSPITAL IN WESTERN CAPE.

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

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

**Karl Bremer Hospital
Eerste River Hospital**

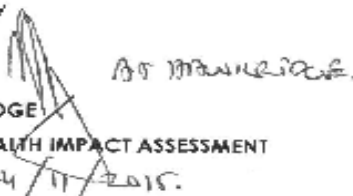
**L Naude
A Hazekamp**

**Contact No: 021 918 1222
Contact No: 021 902 8036**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (annexure 9) within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
3. The reference number above should be quoted in all future correspondence.

Yours sincerely


DR A HAWKRIDGE
DIRECTOR: HEALTH IMPACT ASSESSMENT
DATE: 24/11/2015.
CC M PHILLIPS
A PATIENTIA

**DIRECTOR: KHAYELITSHA/ EASTERN
DERECTOR: NORTHEN/ TYGERBERG**

APPENDIX E: Request to collect data

Van Bruggenlaan 13
Hoheizen
Bellville
7530

Dr. W Viljoen
Helderberg Hospitaal
Somerset Wes

28 Augustus 2015

Geagte Dr W Viljoen

Toestemming om data in te samel

Ek is 'n student by die Universiteit van Wes Kaapland; Studente no: 3312233 en is besig met my Meestersgraad in Verpleging. Die naam van my tesis is:

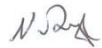
The experiences of professional nurses working in district hospitals where the 72-hour assessments of involuntary mental health care users are conducted.

Goedkeuring vir die navorsingsprojek is verleen deur die Navorsings-etiese komitee van UWK. Die Registrasieno is: 14/5/28.

Hiermee versoek ek goedkeuring om onderhoude te voer met geregisteerde verpleegkundiges wie werksaam is in die 72-uur assesseringseenheid. Afsprake vir die onderhoude sal gereel word sodat daar nie enige negatiewe impak op die werksaamhede in die saal sal wees nie.

Kontak my gerus indien u meer inligting verlang.

Vriendelike groete



Verna van Zyl (Mev)

Werk: 021 9404458

Selfoon: 083 2852627



APPENDIX F: Request to collect data

Van Bruggenlaan 13
Hoheizen
Bellville
7530

Mev. D Barnes
Karl Bremer Hospitaal
Bellville

27 November 2015

Geagte Mev. D Barnes

Toestemming om data in te samel

Na aanleiding van ons telefoniese gesprek die volgende. Ek is 'n student by die Universiteit van Wes Kaapland: Student no: 3312233 en is besig met my Meestersgraad in Verpleging. Die naam van my tesis is:

The experiences of professional nurses working in district hospitals where the 72-hour assessments of



APPENDIX G: Information Sheet



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9599345, Fax: 27 21-9592679

E-mail: pmartin@uwc.ac.za

INFORMATION SHEET

Project Title: The experiences of professional nurses working in 72-hour assessment units in district hospitals in the Western Cape metropole

What is this study about?

This is a research project being conducted by Verna van Zyl at the University of the Western Cape.

We are inviting you to participate in this research project because you are a professional nurse who works in the medical ward where the 72-hour assessments of involuntary mental health care workers are conducted

The purpose of this research project is to get first-hand information from professional nurses who are experts in their field, in order to provide scientific evidence which can then be rendered to the managers and healthcare policy makers to improve the environment for the patients and the health care workers.

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

You will be asked to participate in a maximum of two semi structured interviews to explore how you experience working in a 72-hour assessment unit. You are requested to provide specific situations, experiences, or examples (present or past) which you remember at this moment. Try to be as clear and specific as possible without being very general, e.g. "*the experience was good*". The duration of the interviews should be no longer than 30 minutes.

Would my participation in this study be kept confidential?

We will do our best to keep your personal information confidential. To help protect your confidentiality all the information will not be permissible to anyone outside the research team and we will never mention your name in our records. If we write a report or article about this research project, your identity will be protected to the maximum extent possible.

What are the risks of this research?

There are no envisaged potential risks identified. If any psychological/emotional distress as a result of this study are experienced, I will make sure that you are referred an appropriate empathetic specialist who you can talk to.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator learn more about the experiences of professional nurses working in 72-hour units and the functioning within these units. We hope that, in the future, other professional nurses might benefit from this study through insights gathered in this study.

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

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

Is any assistance available if I am negatively affected by participating in this study?

You will be referred for counselling if you experience any psychological/emotional distress as a result of this study.

What if I have questions?

This research is being conducted by Verna van Zyl with Dr P Martin (study coordinator) at the University of the Western Cape. If you have any questions about the research study itself, please contact

Dr P Martin at: 021 959 9345; pmartin@uwc.ac.za

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

Head of Department: Head of Postgraduate Studies: Professor O Adejumo

Director of the School of Nursing: Professor K Jooste

Faculty of Community and Health Sciences,

University of The Western Cape.

P/Bag X17

Bellville

7535

021-959 2271

Supervisor: Professor O Adejumo

This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.

APPENDIX H: Consent Form



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9599345, Fax: 27 21-9592679

E-mail: pmartin@uwc.ac.za

CONSENT FORM

Project Title: The experiences of professional nurses working in 72-hour assessment units in district hospitals in the Western Cape metropole

The study has been described to me in a language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

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

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

- **Participant's name:**
- **Participant's signature:**
- **Witness's name:**
- **Witness's signature:**
- **Date:**

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the researcher.

Study coordinator: Dr. P Martin.

University of the Western Cape

Private Bag X17, Bellville 7535

Telephone: (021) 959- 9345/2271

Cell: 0725742360

Fax: (021) 959- 2679

Email: pmartin@uwc.ac.za

APPENDIX I: Interview Guide

INTERVIEW GUIDE

These questions are the themes but specific probing questions regarding specific incidents will be elicited during the interviews to obtain rich information.

Questions	Probes
<p>1. Please tell me how does 72-hour assessment unit function in the district hospital?</p> <p>2. Please explain to me the challenges you have experienced with regard to the integration of the 72-hour assessment unit within the district hospital.</p> <p>3. What changes within the district hospitals would you suggest to improve the functioning of the 72-hour assessment units?</p>	

APPENDIX J: Transcript of interview P007

I = interviewer; P = participant

I How do you experience this 72-hour assessment unit?

P It is very challenging for me, but I do enjoy it. Every day I enjoy it. I have actually been working here for the past eight years and like, starting from where we were when we started this.

I Tell me a bit more, where you started?

P When we started it was a male and female ward. We had males and females, we had different patients; medical and surgical patients and ok the staff, we had a bit more, staff working here, but it was much, much more busy. We had theatre cases on a daily basis and then, but the psychiatric patients weren't that much and they weren't that disruptive and umm sometimes, like I can I say, unmanageable. That time they were more, ja more manageable that time. It was very busy ja, and as time goes on we moved the females separate and then, like at this stage, we don't have, we only have psychiatric patients. We don't have more medical patients. If there is a patient like for instance delirium patients, an elderly patient who comes with delirium, dementia that is the, like by far the most medical that we do get here.

I Ok, so you put them in this ward?

P Yes, but otherwise the females we get, because at time it depends, we don't get as much psychiatric female patients than we get the males these days, so we put them, there is a pressure for beds, we put the medial patients, say for instance if the medical wards are full, then we put the stable medical patients in the, together with the psychiatric females, but it does not really happen with the males any more, it used to be, because of the high risk that goes along with.

I You spoke now of the challenges, what would you say is the challenges?

P The challenges for me mostly are about the safety, the safety of the staff and the safety of the patients, mostly. The staff attitude, the staff not being like trained or knows and sometimes not really equipped to work with these kind of patients, but as time goes on we try (patient comes in)

I Ok, you've mentioned now quite a lot of things about the staff not being trained. Are there staff here that doesn't want to work with psychiatric patients?

P Not at the moment, no. The hospital do the rotation throughout the hospital when they rotate we do get staff members from another wards, then they like, I think most of them they are scared, because they don't really know what it is about. But we get it like with everybody, especially, like even the professional nurses also, they rotate during the throughout the hospital, then when they get here, they're scared, but when they are actually here,

they are actually doing the work and then actually enjoying it at the end of the day and then they don't want to go out of the ward again. So it is actually, most of the time, it's very, everybody experience it, as a pleasant experience working here. The people that rotate throughout through the ward.

I Where you ever scared?

P Hmm, yes, (silence) in the beginning, but not I would say, not anymore.

I Now if you see a patient is unmanageable, do, do you, how do you go about it, do you call the security, do you get the injections or?

P Some of the other challenges that I did come across in the ward is our security is not also not trained to work with the patients. So I would rather approach the patient that is only for me, with my experience with the patients. I have got my way, the manner in which I am talking; I am a soft spoken person, so I know by now how to approach them. So like for instance, I will approach them first, it also depends on the patient, how aggressive the patient is and the state the patient is in, before I call the security, but our security always follows us wherever we go. So security is always everywhere, going everywhere.

I Do you only have the one security?

P We have 2 securities. There is one by the gate and one is supposed to be at the back, but the one at the back patrols the passage.

I So at least you've got two securities. The sister told me that she is worried about, sometimes the juveniles that they and you don't know how to manage, sometimes because they're very, hmm react in a different way than what you've expected. Have you also experience something like that?

P Yes, yes, the same, but we've tried to keep them away from the rest of the patients, because they're easily influenced by the other patients and they need to be handled differently, like the other patients, so what we usually do is we usually have a single room in the by the female side, so we usually put them there with the security that looks after, one security, male security that looks after that patient and see at all times, but it doesn't really happens that often that when that patient is violent that side, they need to be secluded here, because we don't have seclusion rooms on the female side, then the patient needs to come over. I, most of the times I work by the males, I enjoy working with the males more than with the females.

I Why would you say, what is it about females?

P Grins, I don't know, this morning I was talking to another colleague of mine, because she is just going on leave and I am supposed to relieve that side, but I need to prepare myself to go and work there. The females, it's like, for me they are more aggressive towards the female staff in the ward, they more like reactive also. Like for the male patients, I don't think also, the male patients will be so aggressive towards me as a female sister, than the female patients, that is what I've come across over the years.

I So the behaviour is much more exposed

P Yes, they are more argumentative like for instance, if I tell the male patient it is not your smoking time now, and the patient will understand, but if I do it to the female, then she want to know **why** and things like that.

I And how do you feel about that?

P It's like for me to be hmm, like, to be hmm how do I say now, the females they are, they like to provoke the staff. I think that they provoke us and I try, I have to contain myself. I don't know if it's a female thing or a hormonal thing or, but I really have to be very patient and to think twice before you say anything.

I Oh, so you're not so looking forward would you say, to work on that side.

P Not that I am not looking forward, because when I'm working there, I actually enjoy it, but mean just that mental preparation thing and I need to, because I've been working here for so long, the whole year. So I haven't worked this year, this whole year, I haven't worked with the females. So I have to prepare myself mentally. Yes, yes, but if I'm there then it goes well, so it's

I I have also asked some of the other, the challenges in the ward, the hmm if you look at the facilities. Are there still any challenges what would say about the facilities in the ward?

P Yes, we do have a lot of challenges in the ward with the facilities self, because I don't know whether we are really, hmm. We have our seclusion rooms, but then the patient's still have a 4 bedded room; the separate rooms with the 4 beds in the rooms. Ok, so at nightshift we have to, at night duty we have to watch them. We sit in the passage and have to watch them, but It is always when you enter the room, you know, you don't know who is hiding behind this curtain or doing so and I don't know; the patients break a lot of things in the ward, like on a daily basis we have to repair things. They break the toilets, they break the the taps, they break the windows. Some of them they've got aggressive outbursts, most of them, like all of them, they don't believe that they are sick, they don't want to be here, they feel they're being locked in a jail, behind a gate and, so most of them don't get visitors and all of that frustration, then they see the doctor, then they, they're on a waiting list and all of them, some of them have been here very long, some of them have been here more than a month. They're on the waiting list to go to Lentegour or another long-term facility and unfortunately they they don't have beds immediately there, so they are just here and the plan is for them to wait, until...

I Do you think if they could go outside maybe or do some exercises or hmm take part in a program, do you think that would help them?

P Definitely, definitely, but some of them must go. This is like an acute, they cannot, because what we do is, over week-ends, we try to do things with them and with the females, we watch movies, we do the papering with the nails and that goes well. With the guys, it is not really easy, ok, they do play dominos and cards and things like that, but I'm sure they would like to go outside and, but the thing is we've tried. We've come a long way, because we've got, they smoke, so we do allow them to smoke, so we've come a long way. They used to go outside to smoke, then they run away and then we have to chase after them (laughs) and that happened a lot, on a

daily basis. I told the new doctor that was here, like I was pregnant, about 32/33 weeks and I had to chase after a patient, because they just kick the gate open. We have a more steady gate now. That time the gate, they could open the gate and they would run, on a daily basis. That happened on a daily basis, then the staff would say, oh, Sister, you again, running after a patient (chuckles), things like that, but it was exciting. We've enjoyed it, but we've come a long way from where we were, to where we are now, but we still need to do a lot more, but like I said many things improved since 2008.

I How do you think the other, your colleagues in the other wards, do they stigmatize you, because I've heard just now that one of the sister's said that they actually, make comments on the sisters' working permanently like in the psychiatric ward. Have you experienced something like that?

P Not me, myself, I haven't experienced that, but I do know some of the nurses says that when they, for instance they come across or when they work in other wards, sometimes they take them out to other wards and sometimes they make a mistake and they say; no, you're from that crazy ward or like, the staff acts like the patients now or something like that, but not, I didn't for me personally, no, I didn't come across that.

I How do the medical patients, the visitors, how do they manage this or how do they feel about their families lying amongst the psychiatric patients?

P Very very difficult, they are very difficult when they come visit. First of all they see there's a locked gate and their family member maybe came for, who maybe came for instance an appendectomy, is locked under and he is amongst different people, who are wandering up and down, people that are talking to themselves, they are singing out loud and they don't understand. Then sometimes they become very very difficult towards us and they are very demanding, but at all times as far as possible we try to explain to them and even to the patient himself, for instance if there was a patient that they say that book this patient for instance from the Emergency Centre then I will tell them; can you please explain to the patient where he is going now. Even with the voluntary patients also, because we do get the voluntary patients and it is also another major challenge that we have with the voluntary patients who hmm, but most of the times we have involuntary patients in the ward, so they are not allowed to go out, but with the voluntary patients which will be different in that case to the involuntary patients. We used to, on a Sunday when we have Church services and then voluntary patient will go to church, but then the involuntary patient will not understand why he cannot attend church, then they are difficult. I've noticed that when you explain to a patient beforehand what to expect, when they come here and then the patient can explain to his visitors also what to expect when they come here. Then it makes a difference then they are fine with it. But then as far as possible we put then our restless patients at the back of the ward and then the others, we try to put in front.

I Would you like changes; not the small rooms, this 4 bedded wards? Would you like to have a bigger room or would you like to have CCTV cameras

in the bedrooms or what would you like to change in that sense, because I have seen now, they have taken out the baths, they put in showers now, which is actually now easier.

P Hmm, it would be easy if we could have a view of the whole ward, like one nurses station in the front and then all the patients we can view at once, because it is difficult if we are 4 nurses and like we allocate each of them to a room, but then what happens to the other rooms, then you can't have an eye 24/7 over there. It becomes difficult during the day also when there is only one nurse and then you can't be everywhere all the time and you can't see what the patient is breaking. The patient is breaking off the tap and he uses the tap as a weapon to stab security, who doesn't want to open the gate for him, because he wants to go home, because he feels he doesn't belong here.

I So that has happened?

P Ja, a lot (exhales). It happened last week or 2 weeks ago.

I Were you on duty?

P Yes, I was on duty

I And then what? What if something like that happens? How do you handle that, how do you feel about that?

P Hmm, luckily I have a good rapport with my patients in the ward, especially the ones I get to know and the ones that has been here longer. I also make time for them and hmm build their confidence and build trust. Ja, build trust with them and on that specific day, it was on a week-end, I didn't know that the patient, I actually saw the patient coming towards the security in front and he had this sharp thing, shiny thing in his hand. I didn't know where he got it from, because we do search them and make sure they don't have any weapons or objects or whatever and luckily there was another patient. It was only me and security and one nurse, and luckily another patient came from behind and he grabbed it from him, because the poor security was so scared, he didn't know what to do. He ran for the radio to call for back-up, but it was taking so long, the patient was so, he was very angry at the security, but luckily nobody got hurt.

I Was it an adult patient?

P It was an adult.

I Apparently the juveniles also get quite, physical.

P Yes, yes, they do get quite physical towards the security. Shame the poor securities get, they also get assaulted. Yes shame, they do.

I Yes, so it is quite difficult. Your experience, your feelings about psychiatry and being in this ward, can you explain that a little bit? Tell me about that?

P Like hmm (hesitant)

I Have you been afraid or have you had bad experiences? Have you had, felt as though you have failed or not really? Could you overcome all of those things?

P Hmm, Like I said, I started here in 2007 and this is basically all I know, from after I have finished my four years nursing course. So this is actually my life. There were a few times, there were many obstacles throughout the year. There was one specific incident in 2010, where a patient jumped off the roof, and he killed himself and I was on duty. That time, it was a big

thing. I felt like I failed the patient, I felt like hmm, but I did overcome this, I can talk now like I know, it was something out of my control and there was really nothing I could have done hmm to prevent the patient from killing himself, but at that time, I felt like I failed my patient

I Did they send you for support?

P Yes, they did

I From the hospital's side?

P Yes, from the hospital's side. They were very supportive that time and it was very amazing that, how supportive they actually were and that also made a big difference in me overcoming everything, because to me it wasn't, it wasn't like blaming like where were you, what were you doing?

I Yes, because it could easily have put you off completely, but it changed you, in a sense that you love psychiatry?

P Yes, I do love it.

I Hmm, so you can actually speak now to say that you, that you I like to be here, this is for you?

P Yes, like I am going to do the Advanced Psychiatric course next year and that is what I'm been looking forward since I've been working here, because I like want to do more for the patients and I want to do, because the doctors that have been here, they come and they go, all the time, they like stay for 6months, not more than 6months and then they feel the pressure is too much, the workload is too much and like I always feel, surely there is something more I can do to make it better for them or, I don't know in which way, but it is always, I feel like maybe we can do more, me as a professional nurse can do more to make it better for everybody, the patient.

I Hmm, is, how is the relationship between you and the, the nursing staff and the doctors?

P We work very well together. We've got one specific doctor here, he has started here in the beginning of his year and he hmm, actually it's the best relationship we've had. With the other doctors, I don't know if some of them really, it feels sometimes that their heart is not here, they're just here and it doesn't like hmm, but this doctor really he looks, he takes us every day with a round, together with him, he takes all of our opinions and he involves us, so that it makes us feel much more, even the nurse, not even me, the sister like me. If I'm on tea, or not here, he will ask the nurse; "what do you think about that patient" and, but then in the morning we do have a discussion about all of our patients and then at hand-over, after hand-over everybody gets to say what they think of that patient, how that patient were, because some of the hmm Xhosa speaking patients, I really don't know how, that other nurse maybe picked up something that I that I missed and then we discuss the patient in general that we can

I At least. I have seen in some of the other places also that, the fact that sometimes the doctors are not, especially the night sisters don't feel that the doctors is actually working together with them.

P Our doctor actually comes 7 o'clock in the morning and each morning before I knock off, he will tell me; "hey, what do you think about sending that one home, what do you think about that one, quickly". This morning

he said; “when are you coming off night duty, I feel like, I need your input here. I said; no, don’t worry I do make a note in my morning report, I do make a note for him about my observations of the patients throughout the night and he do, does take that into consideration and it helps him, because shame, he sees the psych patients and the other side and sometimes they call him down to EC and he can’t get to all the patients every day, all the time.

I So he has to do the 72-hour assessments?

P Yes,

I And a lot of the patients they go home from here, they don’t go to the other hospitals?

P Yes, they do.

I And that, how do you feel about the patients staying so long here? Waiting to go to another place to be helped?

P I feel, in a sense helpless, because sometimes I can see the patient’s medication is being adjusted, but he is not getting better, then it feels like really, what are we doing wrong for this patient. Doctor has increased the medication and but still the patient is getting worse and sometimes, or the patient is getting, is really not getting better and the patient has been there for more than 2 months. We had a patient now waiting I think last week he was transferred to Lenteguur Hospital. We don’t have that problem with Stikland Hospital, but it is mostly the Kayelitsha patients that we have a lot of, not problems, but things like they’re stuck here and they’re not getting better. It feels like we’re not really helping the patients here, because the patient is waiting for a bed to go, but in the meantime he is not really getting better. He is just waiting and waiting.

I Why are those patients not going to to Mitchells Plain and Kayelitsha hospitals. The patients, why do they come here?

P I really don’t know

I Is it because, they are full or don’t you know why? It is also quite far for their visitors, if they come here.

P That might be, because there is not so many visitors coming here. There is a part of Kayelitsha that goes to Mitchells Plain. I think the other part of Kayelitsha still falls under our drainage area, that’s why they come here.

I Ok, so they do have to come this side. Ja, so you say and you are going now to do Advance Psychs at WCCN. I will see you there.

P Ok, (laughs) I am so looking forward to it.

I Thank you. I am going to stop here

APPENDIX K: Editorial Certificate

07 August 2016

To whom it may concern

Dear Sir/Madam

RE: Editorial Certificate

This letter serves to prove that the thesis listed below was language edited for proper English, grammar, punctuation, spelling, as well as overall layout and style by myself, publisher/proprietor of Aquarian Publications, a native English speaking editor.

Thesis title

THE EXPERIENCES OF PROFESSIONAL NURSES
WORKING IN DISTRICT HOSPITALS IN THE WESTERN CAPE
METROPOLE, WHERE 72-HOUR ASSESSMENTS ARE CONDUCTED


Author

Verna van Zyl

The research content, or the author's intentions, were not altered in any way during the editing process, however, the author has the authority to accept or reject my suggestions and changes.

Should you have any questions or concerns about this edited document, I can be contacted at the listed telephone and fax numbers or e-mail addresses.

Yours truly,



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APPENDIX L: Western Cape Districts Map

