

**THE EXPERIENCES OF NON-PSYCHIATRIC TRAINED PROFESSIONAL NURSES
WITH REGARD TO CARE OF MENTAL HEALTH CARE USERS IN THE
SEKHUKHUNEDISTRICT, LIMPOPO PROVINCE**

BY

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DECLARATION

I, Nancy Netshakhuma, declare that the dissertation “The experiences of non-psychiatric trained professional nurses with regard to care of mental health care users in the Sekhukhune District, Limpopo Province” hereby submitted to the University of Limpopo, for the degree Master of Nursing Science has not previously been submitted by me for a degree at this or any other University, that is my work in design and in execution, and all materials contained herein have been duly acknowledged in both the text and in the list of references.

N Netshakhuma (Miss)

Date

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CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND

There is a serious shortage of properly-trained Mental Health Nurses in the National Health Services, and this situation is creating severe difficulties in the delivery of high-quality mental health care. The problem is particularly severe in acute wards in patient settings, as highlighted by recent research (Sainsbury Centre for Mental Health, 2008), and particularly in inner-city services (Ward, 2008).

The report addressing Acute concerns (Department of Health, 2010), produced by the Standing Nursing and Midwifery Advisory Committee (SNMAC), highlights specific gaps in the knowledge and skills of mental health nurses who work in acute ward in patient settings that are not addressed by current educational and training provision. This report recommends the development of post-registration and post graduate courses in the nursing of mentally ill patients in the acute phase of their illness. The report suggests that such courses should include: formal assessment; risk assessment and management; working with users and carers; and using evidence-based interventions in practice (Department of Health, 2010) and implementing the National Health Services Plan (Department of Health, 2006), has focused on workforce planning, education and training issues for all mental health professionals working in adult mental health services (DOH, 2006).

A report by the Mental Health Information Centre (Science in Africa, 2007) indicates that one in five South Africans suffer from mental disorders severe enough to negatively affect his/her life. The report stated that roughly 25% of all patients presenting at general practitioners' consulting rooms as well as clinics are ill mostly due to psychiatric rather than medical conditions. Unfortunately, these are often misdiagnosed and treated as medical conditions. A number of factors can be attributed to this, and these include an inability, by some practitioners to properly diagnose psychiatric disorders as well as the fact that most South African people do not necessarily conceptualize their problems as being psychiatric in nature (South African Health Information, 2004).

In addition, a large number of people still attach a great deal of fear and shame towards the mentally ill, possibly because of religious and cultural myths and beliefs. What is unfortunate is that health care professionals are also reported not immune to feeling negatively disposed towards mentally ill patients (Brink, 2010). Because of this, and other problems in the mental health sector, there has been a growing need to provide practitioners with additional training to help them provide a more holistic care that will also address problems which are psychological in nature.

A number of researchers (Mavundla, 2003; Uys, 2010) and other institutions of higher learning such as the Community Mental Health Programmes (CMHP) heed the call and designed programmes that were for the purposes of training nurses, doctors and community health workers in mental health care. Psychiatric acute wards are specific segments for caring mentally ill adults. Psychiatric urgent refers' to "an acute disturbance of thought, mood, behaviour or social relations that requires direct confrontation" (Allen, 2012). Nursing staff in acute psychiatric wards usually has to take care of violent, aggressive and possibly suicidal patients (Eaton, 2014). Continuing nursing education according to American Nurses Association (ANA) refers to educational activities that provide knowledge, aiming at the improvement of provided services (Pena & Castillo, 2006). The need for the training of psychiatric nursing staff became perceptible very early (1854) in Scotland, where the first system of education of Psychiatric Nurses was established.

Doyle (2008) studied the 2 day training programme concerning the risk assessment. All of the participants (100 %) declared that the training had positive effects on every day practice even after 1 year of the seminar. Research concerning the training needs of nursing staff in acute wards in Great Britain, indicated that the personnel asked training specifically on issues suitable to every day practice. Main thematic was: Risk assessment, working with people personality disorders, management of violence and aggression, psychosocial interventions, working with people with dual diagnosis (drugs and alcohol) and people with psychosis (Jones, 2007). Clarke (2004) revealed the lack of training program according to real educational needs of staff in acute segments. A national survey of training needs assessment in Ireland highlighted the need for further education in: Risk assessment, Management of violence and aggression, the suicidal patient, legal issues and communication skills (Brennan, 2006). Most recent study suggested inter professional training on: Management of violence and aggression and patients with personality disorders (Mason, 2008).

The number of Europeans suffering from mental health problems continues to rise and this trend is likely to continue (WHO, 2005). Commitment to the improvement of mental health services in all European States was expressed by the European Ministries Conference on Mental Health held in Helsinki in January 2005. The conference acknowledged that mental health is Fundamental to the quality of life and to the productivity of individuals, families, communities and nations enabling people to experience life as meaningful and to be creative citizens. The primary aim of mental health care was defined as to enhance well-being and functioning by focusing on people's strengths and resources, building up their resilience by strengthening protective external factors (WHO, 2005a). For this to happen, mental health services require sufficient personnel, appropriately trained with the skills to work flexibly in integrated teams and having adequate resources. To combat the morbidity, disability and mortality arising from mental illness, WHO (2005) has focused on the need for well-educated and skilled nursing staff.

The Munich Declaration (WHO, 2010) state that nurses are both the most appropriate personnel to tackle the public health challenges of our time and also the most cost-effective. If nurses are to realise their full potential to assist the health of the citizens of Europe, they need a well developed knowledge base, specialist skills in caring and in the technological dimensions of treatment, and proficiency in making clinical judgements both autonomously and as members of multidisciplinary teams. Most European Directives are aimed at medicine and nursing in general, and not at specific specialities within these professional (Mossialos, 2013) and it would appear that interest in mental health nursing is waning in Europe (Healy, 2012). The paper aims to establish how various European countries prepare nurses to work in mental health settings by: Establishing how nurse education is managed in each country. Identifying if and how specialist training is provided for nurses working in mental health settings. Despite the range of studies looking at educational issues for nurses working in mental health settings in individual countries, few studies describe or analyse issues for such nurses in more than one country, and even fewer focus educational issues.

Allen and Brimblecombe (2004) note that common challenges are being experienced by nurses working in mental health settings. Grant's study (2002) of mental health nurses in England and Southern Ireland found substantial disparity in pre-registration mental health nurse training at that time, with England emphasising the specialist nature of mental health nursing, and the Irish taking a far broader approach based on a general health care

curriculum. Smoyak (2006) has recommended that more comparative international studies should be undertaken with the aim of clarifying the role of mental health nurses and their contribution to health care services. Such studies would assist in the development of targeted and effective programmes of education for an increasingly mobile health professional workforce.

1.2 PROBLEM STATEMENT

In this study the problem is the care of mental health care users by non-psychiatric trained professional nurses at Dilokong Hospital, Male and Female Medical Wards in Sekhukhune District, Limpopo Province. Non-psychiatric trained professional nurses experience problems when caring for mental health care users in the medical wards as they are not trained in psychiatric nursing. It is important to understand the experiences of non-psychiatric trained professional nurses with regard to care of mental health care users. The experiences of non-psychiatric trained professional nurses are not known, one can still make assumptions that if they are not trained then it means they do not have expertise in taking care of mental health care users. This will lead to poor nursing care, poor management of mental health care users, it could also lead to litigation because the intervention strategies will not be relevant. This study, therefore, seek to explore the experiences of non-psychiatric trained professional nurses with regard to care of mental health care users.

1.3 THEORETICAL FRAMEWORK

Dorothy Orem developed many theories. In this study two theories will be used; The Theory of Self-Care and Self- Care Deficit. In the Theory of Self-Care, Orem explains what is meant by Self- Care and lists the various factors that affect its provision. In the Self- Care Deficit theory, she specifies when nursing is needed to assist the individual in the provision of self care (George, 2013).

1.3.1 Dorothy Orem Theory of Self- Care Deficit

The theory of Self-Care Deficit is the core of Orem's (1991) general theory of nursing because it delineates when nursing is needed. Nursing is required when an adult is incapable of or limited in the provision of continuous effective self-care. Nursing may be provided if

the “care abilities are less than those required for meeting a known self-care demand or self care or dependent-care abilities exceed or are equal to those required for meeting the current self-care demand, but a future deficit relationship can be foreseen because of predictable decreases in care abilities, qualitative or quantitative increases in the care demand, or both”; when individuals need “to incorporate newly prescribed, complex self-care measures into their self-care systems, the performance of which requires specialized knowledge and skills to be acquired through training and experience”; the individual needs help “in recovering from disease or injury, or in coping with their effects”. In this study non psychiatric trained professional nurses have self-care deficit in caring for mental health care users because they are not trained in psychiatry after being trained in psychiatry they will able to care for mental health care users (George, 2013). Orem identifies five methods of helping:

- Acting for or doing for another such as assisting the sick.
- Guiding and directing, such as advising MHCU’s to avoid alcohol and dagga.
- Providing physical or psychological support such as feeding, helping MHCU’s with exercises, psychological care and therapeutic counselling.
- Providing and maintaining an environment that supports personal development.
- Teaching such as giving health education.

The nurse may help the individual by using any or all of these methods to provide assistance with self-care. Orem has identified five areas of activity for nursing practice:

- Entering into and maintaining nurse-patient relationships with individuals, families, or groups until patients can legitimately be discharged from nursing.
- Determining if and how patients can be helped through nursing.
- Responding to patients’ requests, desires, and needs for nurse contacts and assistance.
- Prescribing, providing, and regulating direct help to patients and their significant others in the form of nursing therapies.
- Coordinating and integrating nursing with the patients’ daily living, other health care needed or being received, and social and educational services needed or being received.

1.3.2 Dorothy Orem’s Theory of Self- Care

Self-care is the performance or practice of activities that individuals initiate and perform on their own behalf to maintain life, health, and well-being. When self-care is effectively

performed, it helps to maintain structural integrity and human functioning, and it contributes to human development (George, 2013). Self-care agency is the human's ability or power to engage in self-care. The individual's ability to engage in self-care is affected by basic conditioning factors. These basic conditioning factors are age, gender, developmental state, health state, socio cultural orientation, health care system factors (i.e. diagnostics and treatment modalities), family system factors, patterns of living (e.g. activities regularly engaged in), environmental factors and resource adequacy and availability (George, 2013). The therapeutic self-care demand is the totality of "Self-care actions to be performed for some duration in order to meet known Self-care requisites by using valid methods and related sets of operations and actions". An additional concept incorporated within the theory of self care is self-care requisites. Self-care requisites can be defined as actions directed toward the provision of self-care. Universal self-care requisites are associated with life processes and the maintenance of the integrity of human structure and functioning. A common term for these requisites is the activities of daily living (George, 2013). In this study psychiatric training will help non-psychiatric professional nurses to care for mental health care users and to be self-cared. Orem identifies self-care requisites as follows:-

- The maintenance of a sufficient intake of air.
 - The maintenance of a sufficient intake of water.
 - The maintenance of a sufficient intake of food.
 - The provision of care associated with elimination processes and excrements.
 - The maintenance of a balanced between activity and rest.
 - The maintenance of a balanced between solitude and social interaction.
 - The prevention of hazards to human life, human functioning, and human well being.
 - The promotion of human functioning and development within social groups in accord with human potential, known human limitations, and the human desire to be normal.
 - Health deviation self-care is required in conditions of illness, injury, or disease, or may result from medical measures required to diagnose and correct the condition.
- They are as follows:
- Seeking and securing appropriate medical assistance.
 - Being aware of and attending to the effects and results of pathologic conditions and states.
 - Effectively carrying out medically prescribed diagnostic, therapeutic, and rehabilitative measures.

- Being aware of and attending to or regulating the discomforting or deleterious effects of prescribed medical care measures.
- Modifying the self-concept and self-image in accepting one-self as being in a particular state of health and in need of specific forms of health care.
- Learning to live with the effects of pathologic conditions and states and the effects of medical diagnostic and treatment measures in a life-style that promotes continued personal development (George, 2013).

In this study, non-psychiatric trained professional nurses will be enabled to care for mental health care users after being trained in psychiatry. MHCU's have self care deficit. Nurses have to create nursing care that will enable MHCU's to care for themselves.

1.4 THE AIM OF THE STUDY

The aim of this study is to explore and describe the experiences of non-psychiatric trained professional nurses with regard to care of mental health care users at Dilokong Hospital, Greater Tubatse Municipality in Sekhukhune District of Limpopo Province.

1.5 RESEARCH QUESTIONS

The following research question guided the researcher during the study:

- What are the experiences of non-psychiatric trained professional nurses regarding care of mental health care users at Dilokong Hospital in the Greater Tubatse Municipality, Sekhukhune District of the Limpopo Province?
- What strategies in place can be used to support the non-psychiatric trained professional nurses caring for mental health care users?

1.6 OBJECTIVES OF THE STUDY

The objectives of this study were to:

- Explore the experiences of non- psychiatric trained professional nurses regarding to care of mental health care users at Dilokong Hospital in the Greater Tubatse Municipality, Sekhukhune District of the Limpopo Province.

- Describe the experiences of non-psychiatric trained professional nurses regarding to care for mental health care users at Dilokong Hospital in the Greater Tubatse Municipality, Sekhukhune District of the Limpopo Province.
- Develop strategies to assist non-psychiatric trained professional nurses regarding to care of mental health care users at Dilokong Hospital in the Greater Tubatse Municipality, Sekhukhune District of the Limpopo Province.

1.7 RESEARCH METHODOLOGY

The qualitative research method was used in this study to explore the experiences of non-psychiatric trained professional nurses with regard to care of mental health care users at Dilokong Hospital in the Greater Tubatse Municipality, Sekhukhune District of the Limpopo Province. Qualitative research is a research method which describes and analyses the human experiences. The qualitative research method has been chosen because it seeks to understand the meaning and interpretation of human experiences while interacting with situations or events (Hansen, 2006). The research design used in this study was phenomenology to get insight on care of mental health care users by non-psychiatric trained professional nurses. The population of the study was all non-psychiatric trained professional nurses who are caring for mental health care users in Dilokong Hospital. Purposive sampling was used and twelve participants were selected for this study. Data collection was done through semi-structured interviews. Tesch's open-coding was used for data analysis. The researcher made a summary of the themes and sub-themes identified before sending the data to an independent coder. The details of methodology will be discussed in chapter 3.

1.8 SIGNIFICANCE OF THE STUDY

The study might bring attention to the Department of Health Limpopo Province, Sekhukhune District, Dilokong Hospital CEO and the Management Team to consider training more nurses in psychiatry. This study will help the hospital to see the need for having more psychiatric trained professional nurses to care for mental health care users as both nurses and other mental health care users are in danger, because nurses are being assaulted by MHCUs every while they are on duty. Results could be recommended to DoH to influence Policy.

1.9 CONCLUSION

This chapter presents an overview of the study. The purpose of the study was to establish the experiences of non-psychiatric trained professional nurses with regard to care of mental health care users at Dilokong Hospital, Greater Tubatse Municipality in Sekhukhune District of Limpopo Province. The chapter further addresses the background of the study, problem statement, research questions, research objectives, research methodology and the significance of the study. The next chapter, Chapter 2 will discuss the literature review.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Chapter one presented an overview of the study. This chapter discusses literature review as a process that involves finding, reading, understanding and forming conclusions about the published research and theory on a particular topic (Burns & Grove, 2005). In the most studies a literature review is done at the onset of the study and is updated or extended during the final phase. The purpose for literature review is to determine what is already known about the topic to be studied so that a comprehensive picture of the state of knowledge on the topic can be obtained. This helps to minimise the possibility of unintentional duplication and increase the probability that new study may make a distinctive contribution (Brink, 2010).

In the UK, there is a serious shortage of well-trained mental health nurses in the National Health Services (NHS), and this situation is creating severe difficulties in the delivery of high quality mental health care. This problem is particularly severe in acute inpatient settings, as highlighted by recent research and particularly in inner-city services. The report *Addressing Acute Concerns*, produced by the Standing Nursing and Midwifery Advisory Committee (SNMAC), highlights specific gaps in the knowledge and skills of mental health nurses who work in acute inpatient settings that are not addressed by current educational and training provision (DOH, 2010).

This report recommends the development of post registration and postgraduate courses in the nursing of mentally ill patients in the acute phase of their illness. The report suggests that such courses should include: formal assessment; risk assessment and management; working with users and carers; and using evidence-based interventions in practice (DOH, 2010). The report calls for urgent action to develop practice-based, post-registration training, as well as a career structure, for mental health nursing working in acute inpatient psychiatric settings. There was a study conducted between October 2010 and February 2011 on mental health nurses working in acute inpatient psychiatric settings in four different NHS trusts based in the South of England and Midlands. The mental health nurses interviewed were very clear that they did both need and want post-registration education and training, specific to acute

psychiatric nursing. However, they stressed that any education and training has to be highly relevant to their day-to-day work in acute psychiatric settings. The discussions within the different groups highlighted the fact that different nurses require different types of education and training to suit both their individual needs at different stages of their nursing careers and also to match the needs of working within different nursing teams and with different clients groups (DOH, 2010).

The mental health nurses discussed many different areas of education and training that they felt they required. The areas of need mentioned frequently and stated to be very important includes: risk assessment; managing violence and aggression; psychosocial interventions; working with people with a dual diagnosis; working with people with personality disorders; IT and computer skills, and leadership skills. The nurses interviewed talked about a number of different problems that they have either encountered or else perceive as barriers to receiving education and training. There are two issues: First, that training is not always available, either because a course does not exist locally or because funding is unavailable in the trust for nurses to attend training courses. Second, that training may be available but nurses have difficulty in gaining access to it due to such problems as staffing shortages (DOH, 2010).

The mental health nurses who participated in the focus groups expressed the overwhelming view that they wanted any training they undertook to be of value and to be recognised by their employers and other organisations. For training to impart new knowledge or to deliver information updates the most favoured method is teaching seminars. But for training in practical nursing skills, the most popular method of delivery is practical teaching sessions. Nurses talked about the value of having the support of a skilled and experienced practitioner, who could provide training and ongoing support for nurses. This expressed 'need' for experienced mental health nurses on the wards, to provide support and guidance, reflects a national recognition of a lack of clinical leadership in acute inpatient areas at present. The government review of mental health nursing suggested that service users should develop roles in curriculum development and teaching. The view that professional education was in some way detrimental to an individual's human and caring qualities was held strongly by several participants. As one person stated: 'The most important thing nurses can do is abandon their training' (DOH, 2010).

2.2 HISTORICAL OVERVIEW OF CARE OF MENTAL HEALTH CARE USERS BY NON-PSYCHIATRIC TRAINED PROFESSIONAL NURSES

Nursing staff in acute psychiatric wards usually has to take care of violent, aggressive and possibly suicidal patients. Continuing nursing education according to American Nurses Association (ANA) refers to educational activities that provide knowledge, aiming at the improvement of provided services. Dickerson (2005) defines continuing nursing education as a continuous process of knowledge and skills acquisition, a part of the initial education, aiming at the professional growth. A research in Winchester in G. Britain regarding the educational needs of nursing personnel, in acute segments, revealed in general the personnel's intense wish to undertake an educational program for dealing with acute incidents (Eaton, 2014; Pena & Castillo, 2006; Dickerson, 2005; Clinton, 2007).

Doyle (2008) studied the two days training program concerning the risk assessment. All of the participants (100 %) declared that the training had positive effects on every day practice even after one year of seminar. Research concerning the training needs of nursing staff in acute wards in G. Britain, indicated that the personnel asked training specifically on issues suitable to every day practice. Main thematic was: Risk assessment, working with people with personality disorders, management of violence and aggression, psychosocial interventions, working with people with dual diagnosis (drugs and alcohol) and people with psychosis. The preferred method of training delivery was short practical teaching sessions (Doyle, 2008; Jones, 2003).

A national survey of training needs assessment in Ireland highlighted the need for further education in: Risk assessment, management of violence and aggression, the suicidal patient, legal issues and mental illness and communication skills. Most recent study suggested interprofessional training on: management of violence and aggression and patients with personality disorders (Brennan, 2006; Mason, 2008). A study of users of mental health services in New Zealand found that Mental Health Nurses should be professional, convey hope, know and respect the client, work alongside the client, privilege human quality and be able to connect with clients. Furthermore, they should have good interpersonal and practical skills, a high level of personal and professional knowledge and be able to view the client in context. Ramritu and Barnard (2008) describe skills and attitudes as essential for successful practice. Using this framework, this study (The Mental Health Nurse Incentive Program)

presents the skills and attitudes suggested for MHNs working in the Australian MHNIP (Rydon, 2005; Ramritu & Barnard, 2008).

The ability to promote and educate other professionals about the role of MHNs in primary practice was also identified as an important skill because of the apparent ignorance and stereotypical views about what MHNs can actually do. Also, because the MHNIP is a relatively new initiative in health, many primary health practitioners have little or no understanding of the programme. Nurses are generally found to be non-assertive, and the reasons for this are often complex. However, assertiveness is a valued behaviour because of its contribution to leadership, quality patient care and increased job satisfaction. In an Australian study involving women community mental health nurses, Rose and Glass (2006) found that the ability to speak out contributes to the emotional well-being of mental health nurses, ultimately leading to satisfying professional practice (Carten & Hargie, 2004; Rose & Glass, 2006).

Active collaboration with consumers is considered a core value of all mental health nursing practice. The Mental Health Nurse Incentive Program was introduced to increase access to mental health services. The success or otherwise of this strategy is largely dependent on the extent to which mental health nurses are able to meet the mental health needs of clients accessing medical care from general practitioners and psychiatrists. The findings of this research suggest that nurses working under the MHNIP have specific skills and attitudes essential to providing the care and treatment required in this setting. This contribution to knowledge provides the foundation for further research to articulate the role of mental health nurses under the MHNIP (Pegg & Moxham, 2008; Jubb-Shanley & Shanley, 2007).

Nurse prescriber training is relatively generic in nature and therefore relies somewhat on the nurse themselves to apply it to the mental health context. According to the guidelines 'Improving Patients Access to Medicines', the aim of nurse prescribing are to improve patient care without compromising safety, improve access to medicines, increase patient choice, improve flexibility within the team, and utilize existing skills among nurses. Harrison (2009) found that there were concerns regarding the need for nurses to be adequately educated and supported in this function, and that their role as a nurse was not affected and undermined in anyway (Harrison, 2009).

Hemingway and Ely (2009) reported that the future of nurse prescribing in mental health relies on careful planning and implementation, and requires the organization and individual to be fully aware of the implications of training and practice including role change and responsibility. This may help to further explain why in this case study one nurse was trained but non-practising. As found in a recent review of the literature, current educational programmes appear inadequate, and further updates and learning on the part of the nurse are vital. Equally, the issue of specific mental health training may be necessary. This is an issue supported by Wells (2009) on view on nurse prescribing: a survey of community mental health nurses in the Republic of Ireland who identified that 98 % of nurses in their study reported a need for more training in Psychopharmacology (Hemingway & Ely, 2009; Creedon, O'Connell, & McCathy, 2009; Wells, Bergin, & Gooney, 2009).

Snowden and Martin (2010) conducted a qualitative study using grounded theory to analyse interview data from service users, nurse prescribers and managers in mental health. They found that nurses continue to struggle with balancing their role as prescriber and nurse; however, successful nurse prescribers are able to overcome this through negotiation. They also suggest the need for structured education in better medicines management, as an additional focus. Dobel-Ober (2010) on nurse prescribing in mental health national survey reported that in the UK, 28% of qualified nurse prescribers are non- practising, so the need to consider these issues in future research and at the level of delivering nurse prescribing training and services in an organization is imperative (Snowden & Martin, 2010; Dobel-Ober, Brimblecombe, & Brady, 2010).

Although mental health promotion is a priority mental health action area for all European countries, high level training resources and high quality skills acquisition in mental health promotion are still relatively rare. In the 2008 European Pact for Mental Health and Wellbeing, the European Commission encourages Member States to engage in longer-term cooperation on mental health and well-being in the European Union. It recognises the health, social and economic benefits of good mental health for all and the need to overcome the taboo and stigma still associated with mental illness. To achieve this, the Pact recommends, as a priority area for action for European States, 'promoting training of professionals involved in the health, education, youth and other relevant sectors in mental health and wellbeing'. Promoting mental health has to be seen as a long-term investment requiring long-term education and information programmes. WHO, (2004) report on the Prevention of

mental disorders underlines the importance of capacity building and training health professionals in the area of mental health promotion, urging programme implementers to provide guidelines for training and supervision. Capacity building and training are key issue not only in terms of programme implementation, but also for policy- making, research and advocacy. The report recommends international collaborations to promote training initiatives. In terms of mental health promotion, this would imply not just integrating appropriately trained mental health professionals into general health for social care services but, more importantly, integrating mental health promotion skills into other professional' everyday practice and skills repertoires (WHO, 2004).

Training health and social care professionals in mental health promotion is all the more important in that the principal systematic reviews on this question have found many interventions to be of varying degrees of effectiveness, The recent European Psychiatric Association's guidance paper on mental health promotion asserts the importance of embracing the principle of mental health promotion, but makes little reference to training psychiatrists or other health professionals in this area. Currently, the workforce for mental health promotion varies ably from one country to the next. Although countries such as the Netherlands have created specialised "mental health promotion and prevention workers", high level training resources and quality skills acquisition are rare in Europe, as is training for the quality implementation of mental health promotion programmes. The 2003 –2008 IMHPA (Integrating Mental Health Promotion Interventions into Countries' policies, Practice and Mental Health Care System) project included representatives of 14 European Union countries, five countries in accession (at the time) and Norway, representatives of four European networks and the World Health Organisation. The project developed an internet database of evidence-based mental health promotion and mental disorder prevention programmes as well as a training manual for primary health care professionals on mental health promotion for adults based on developing problem-solving skills. The 2004 – 2006 MINDFUL (Mental Health information and determinants for the European Level) project devised training programme in mental health promotion and prevention interventions as one of its major project outcomes.

The 2007 – 2010 PROMO (Best Practice in Promoting Mental Health in Socially Marginalized People in Europe) project interviewed experts in 14 European countries to identify four components of best practice in promoting mental health in socially marginalised

people: establishing outreach programmes; facilitating access to services that provide different aspects of health care including mental health care; strengthening the collaboration and co-ordination between different services; and dissemination information both to marginalised groups themselves and to professionals. The PROMISE Quality Criteria for Training Professionals in Mental Health Promotion: Embracing the Principles of Mental Health Promotion. The training programme embraces the idea of mental health promotion as distinct from mental illness prevention or curative care. Mental Health Promotion aims to impact on determinants of mental health so as to increase positive mental health and to reduce inequalities (<http://www.biomedcentral.com/1471-2458/12/1114>).

Advocating- The training programme underlines the importance of advocacy, i.e. knowing how to bring out and defend the point of view of people who may not have the skills or the social power necessary to defend themselves or, in the policy area, working for positive change in the social or health care system environment. “Health promotion is not just about changing attitudes and behaviours, but also about defending people’s right to health and changing living conditions. Inequalities in society can lead to poorer mental health for those with less mental health resources. Mental health promotion involves acting upon the determinants of mental health, including clients’ and communities’ social and ecological conditions, income, employment, housing, leisure, daily routines, transport, social and physical environment” (<http://www.biomedcentral.com/1471-2458/12/1114>).

“The training programme underlines how to impact on the determinants of mental health so as to increase positive mental health and to reduce inequalities” or “The training programmes refers to promoting mental health in general or with regard to a specific mental health theme, and not just to preventing mental illness”, proved particularly useful in helping training designers evaluate how well their programmes respected the quality criterion in question. “There is no health without mental health. Mental health is central to the human, social and economic capital of nations and should therefore be considered as an integral and essential part of other public policy areas such as human rights, social care, education and employment”. Multidisciplinary, inter sectoral team-work should be included in the training of all actors. This is particularly true for mental health staff in the context of deinstitutionalisation, with carers and other community stakeholders, including primary care professionals, playing an increasing role in providing support for people with mental health problems (WHO, 2005).

2.3 VIOLENCE IN THE WORKPLACE

The American Psychiatric Nurses Association (APNA), the largest professional organisation for psychiatric nurses, recognizes that violence in the workplace is a pressing occupational concern for all registered nurses and for psychiatric nurses in particular. To examine the scope of the problem and to identify solutions, the APNA chartered a Task Force on Workplace Violence in May 2007. Content experts conducted a comprehensive review of the literature focussing on the following practice areas: inpatient psychiatric settings, outpatient settings, emergency departments, non psychiatric areas such as home care, and academic environments. Based on the findings, the task force developed recommendations for environmental safety, education, and research, both globally and specific to each settings. Violence in the workplace is a pressing concern for nurses in all settings and for psychiatric nurses in particular. In a large survey in 2007, the APNA found that safety is one of the top issues of concern for Registered Nurses (RNs) working in mental health settings.

In May 2007, the APNA board of Directors commissioned a Task Force on Workplace Violence to examine the scope of the problem and to make recommendations for improving workplace safety. Focus areas for the task force included violence on inpatient settings (including private, forensic, and state funded), outpatient psychiatric settings, and other settings, specifically Emergency Departments (EDs) and home care. A volunteer panel of content experts conducted a comprehensive review of the literature in each of these areas of nursing by searching nursing, medical, and occupational health journals from 1970 to 2008. The task force made recommendations specific to each area and assisted in the development of final report. The findings of the task force are included in three position papers on workplace violence: inpatient and outpatient psychiatric settings, other health care settings and schools. Initially, workplace violence was broadly defined as any physical assault, threatening behaviour, or verbal abuse occurring in the work setting or outside the workplace but related to work (Antain-Otong, 2009; Occupational Safety and Health Administration [OSHA], 2008, P.1).

Violence is one of the most vexing and risky hazards facing nurses in the psychiatric health care environment. On July 9, 2008, the Joint Commission issued an alert regarding rude and disruptive behaviour in health care settings. The Joint Commission states that “intimidating and disruptive behaviours can foster medical errors, contribute to poor patient satisfaction and to preventable adverse outcomes, increase the cost of care, and cause qualified clinicians,

administrators, and managers to seek new positives in more professional environments. Safety and quality of patient care is requires teamwork, communication, and a collaborative work environment. To ensure quality and to promote a culture of safety, healthcare organizations must address the problem of behaviour that threatening the performance of the health care team (Love & Elliott, 2013; Joint Commission, 2008). Nurses are three times more likely to be the victims of violence than any other professional group. Three registered nurses in hospitals and five psychiatric nurses and home health aides died as a result of assaults and violent acts in the workplace in 2004. Nurses who have been assaulted experience both physical and emotional consequences including severe injuries due to patient violence tend to be minor, although career-ending incidents involving permanent disability are not uncommon. Caldwell (2006) found that approximately half of the assaulted staff experienced minor injuries. Nijman and Palmstieina (2005) found that only 1% to 5% of the reported aggressive incidents resulted injury requiring medical attention (Keely, 2002; U.S. Department of labor, Bureau of Labor Statistics, 2005; Hunter & Carmel, 2005; Caldwell, 2006; Nijman & Palmstieina, 2005).

The emotional consequences of workplace violence include anxiety depression, insomnia, stress-related disorders, and loss of self- confidence. On September 3, 2006, Wayne Fenton, psychiatrist, researcher, National Institute of Mental Health Scholar, editor of the Schizophrenia Bulletin, and decades- long advocate for people with schizophrenia was shot and killed by one of his patients. Rare and high-profile incidents like this servants chilling reminders of the service provider's vulnerability in psychiatric care. Stalking, sexual assault, and threats are also concerns. Nurses working in some psychiatric inpatient settings are exposed to violence on a daily basis due to the nature of the populations served, the public protection functions of inpatient settings, the culture and demands of the institutional environment, the reduced number of RNs, to lesser-trained mental health workers, and the limitations of the treatment services provided (Gilioli, 2006; Washington Post, 9/4/06; Love & Elliott, 2013; Sandburg, McNeil, & Binder, 2006).

Forensic inpatients generally receive treatment in prison psychiatric facilities or state hospitals. Targets of inpatient violence can include staff, visitors and fellow patients. In a large forensic state hospital in the United States, Love (2013) found that patient-to-patient aggression was more common than patient-to-staff aggression. In a review of British psychiatric hospitals, nursing staff were the most frequent targets of assault. Due to long

exposure and numerous security functions, psychiatric nurses are assaulted more frequently than other members of the interdisciplinary team. Some reports suggest that assaults occur less frequently to female staff members than to male staff. In many psychiatric settings, the least trained staff members (e.g. ancillary staff, aides, mental health technicians, and behaviour specialists) spend the most time with the patient. The training requirements for ancillary mental health workers vary widely from state to state. Many of these care providers are unlicensed and have limited on the job training (Trenoweth, 2010; Hatch-Maillette, 2007; Love, 2013; Quinn & Love, 2008).

To date, there are no national standards for staff training in the prevention and management of inpatient violence. Historically, psychiatric workplace safety programs have been “home grown” programs designed by local staff involving physical tactics for containment, restraint and seclusion, and basic physical self- defence techniques. Farrell and Cubit (2005) evaluated the content of 28 violence prevention and management training programs. They found that the use of restraints, pharmacologic management of aggression, and seclusion were common features. Many violence prevention training programs focus on de-escalation skills for staff, and they teach that observable autonomic arousal (e.g. loud voice, muscle tension, pacing, and pupillary dilation) is a precursor to inpatients’ violent incidents. The patient is visibly upset and getting worse by the moment. Staff members learn to stay calm, lower their voices, and avoid crowding or unreasonable demands (Farrell & Cubit, 2005).

Love and Morrison (2013) noted in their white paper on workplace violence that staff training programs in hospitals should include how to remain safe in a hostage situation. Although hostage taking situations in health care are rare, they can be lethal. It is generally accepted that education and social support should be available for staff after they experience inpatient violence. Often security is not present in outpatient clinics, so mental health staff is vulnerable. Repeatedly violent patients in outpatient psychiatric units are more likely to assault than fellow patients (Love & Morrison, 2013; Blow, 2009). Psychiatric Nurse Practitioner Graduate Training- this educational session will propose a rationale for a standardized psychiatric Nurse Practitioner (NP) training program which would allow the NP to complete their training in a clinical setting. Benefits of such a program would allow for more standardized practice, assure evidence based treatment guidelines are used, increase peer discussion, and foster research. This lecture/poster will provide evidence-based rationale for a psychiatric Nurse Practitioner graduate training program and propose an evidence based

outline of education. The goal is to initiate discussion and begin to pave the way for future programs to evolve.

2.4 TRAINING OF MENTAL HEALTH STAFF

Staff members need to have the appropriate skills to work professionally, effectively and compassionately with people with longer term mental health problems. All staff should be operating with a recovery orientation and have the relevant training to equip them to deliver evidence base interventions (such as medication management and psychological intervention, etc) appropriate to their qualification and experience level in whichever component of the mental health service they work. Training in the use of the national quality standards and guidance on service user experience of care. The primary purpose of National Institute for Health and Clinical Excellence (NICE) quality standards is to make it clear what quality care is by providing patients and public with, health and social care professionals, commissioners and service providers with definitions of high quality health and social care professionals in the use of quality standards (NICE, 2011).

Indigenous conceptions of health and illness need to be incorporated into the training curricula for general and specialist mental health workers. The training of mental health professionals is incomplete, if it does not include exposure to, and collaboration between, the two health care systems that continue to exist side-by-side in South Africa. Training and support should also be provided to supervisory and other management staff in order to develop a leadership culture that is in tandem with the egalitarian principles of PHC. The Independent External Evaluation of Nurse Education and Training in Ireland (Simons, 2008) under the direction of Dr Helen Simmons, and so commonly referred to as the “Simons Report” highlighted the dangers inherent in not specifically identified student psychiatric nurse training needs within nurse training programmes. Cowman (2007) have summarised their study by stating that: “The contribution of psychiatric nurses is central to the mental health services”. Psychiatric nurse must be articulate and assertive in determining their future roles in mental health. Nurses need to be absolute and deliberate in their pursuance of the necessary education, support and autonomy to perform their professional nursing role. (Simons, 2008).

With regard to undergraduate nurse, training is providing the foundation of knowledge and skills, required by nurses to participate in the provision of safe comprehensive and high

quality nursing care along with the promotion of mental health for clients with different mental health problems in a variety of settings. The growing evidence base as to the effectiveness of psychosocial interventions in severe mental illness, combined with improvements in pharmacological interventions, offer a renewed hope for recovery to clients. The more widespread use of psychosocial interventions requires changes in the undergraduate education programmes for psychiatric nurses. Understanding of the mind in health and disease, appreciation of psychological interventions and the fertilisation of experience contribute to the development of a therapist. Many psychiatric nurses go on to train as Counsellors, Addiction Counsellors, Survivors of Adult Abuse, etc. Therefore the review of the undergraduate curriculum could enable us to develop a framework going forward for Personal Development Planning, Training Needs Analysis and Future joint education and training programmes which would re-examine processes of care, interventions and applications to specific services settings in psychiatric (Cowman, 2007).

Staff morale and burnout are important areas to consider in planning for mental health services. Staff often experience burnout because of factors specifically associated with mental health care, particularly when they are “low” in the clinical hierarchy, have the most face-to-face contact with service users, and little say in the nature and organization of their work. Nevertheless, for many people the stress of mental health work can be challenging and provides an opportunity for rewards, as clinicians see improvement in their clients and in the effectiveness of their services. Successful strategies undertaken in New Zealand have included marketing mental health as a challenging and rewarding area of the health sector, and offering a special bridging programme for new graduate nurses to attract them into mental health (WHO, 2005a).

Strategies to improve retention of staff are essential. Staffs that leave the service are often experienced and fulfil a particular function in a team, which makes them difficult to replace by a newly trained individual. In addition to financial incentives, retention can be improved by providing active support, such as the development and implementation of a mental health promotion strategy for staff and improved motivation, through the provision of training, support, supervision and various other incentives (legal, professional, financial, educational or management). In many countries, achieving training goals will require a change in the way in which mental health education and training is conducted. There is often a phase lag in which clinical practice moves ahead of the content of training courses, as their curricula tend

to change outdated or are not consistent with new models of community based care need to be updated (WHO, 2005a).

Once the personnel are qualified, continuing education, training and supervision need to be conducted to ensure provision of the best quality care that meets users' needs: Continuing Education and Training (CET) is in the interests of both the mental health service and the staff for the service, it ensures that care remains up to-date with the evidence for the most effective interventions. For the staff, it ensures that their occupation remains stimulating, and that their working life can follow a trajectory of career-long professional development. Lifelong learning is a cornerstone of continued fitness to practice, and is closely tied with the quality of care and patients' safety. Changing and growing knowledge in the field of mental health means that mental health workers are required to know more and more, compared to what they first knew when they completed their basic training (WHO, 2005a). The situation is further compounded by the shortages within national labour markets of enough professionals to staff either existing service or potential new ones. However, they recognised the limitations of their data because in many countries nurses working with the mentally ill did not comply with their definition, being personnel who had graduated as general nurses with limited and in some cases, no psychiatric preparation at all. The demand for the growth of mental health services continues unabated within EU member states with all the evidence suggesting that mental ill health, and specifically depression, is expected to become the leading health problem by 2020. It is not just nursing shortages causing problems within mental health services but human resource management that need to be examined to establish if adequately trained and prepared in the National Research Report prepared by the Human Resource Development Authority of Cyprus. Nurses who worked in mental health settings have a qualification in the field. All nurses had to undertake a generic programme and register as an RN, and were then legible to work in any of the five clinical practice areas, with the exception of midwifery (WHO, 2007; National Research Report, 2009; Happell, 2009).

Today, in Australia, nearly half of the mental health nursing workforce do not have specialist mental health nursing skills and there is a serious shortage of MHNs both through problems in retaining expert MHNs and in attracting MHNs to the field. If mental health nursing is in crisis, one could argue the whole sector is in crisis. Nurses comprise 77% of the total clinical workforce in mental health care and 99% of the public psychiatric hospital workforce in

Australia, and they are therefore, well placed to provide solutions to come of these problems (AIHW, 2012; Commonwealth Department of Education Science and Training, 2013).

Mental health services implementation in South Africa takes place through national, provincial and district structures. A national mental health authority – the National Directorate, Mental Health and Substance Abuse – provides advice to government on mental health policies and legislation. The lack of appropriate legislation in Nigeria has resulted in their mental health services remaining inequitable, which violates the principles of the primary health care system and essentially provides a vertical rather than an integrated service. In South Africa the need to integrate mental health care into general health care has received particularly strong support. However, the extent to which this model has been implemented and its impact has not been assessed, but there are examples of good practice such as in the Moorreesburg and Ehlanzeni Districts. The use of general health workers, usually with substantial support from mental health specialists in supporting the roles at community clinics, has reduced the gap in mental health services access (WHO- Assessment Instrument for Mental Health Service (AIMS), 2007; World Organisation of National Colleges, Academies & Academic Associations of General Practitioners/Family Physicians (WONCA), 2008).

However, mental health systems in low- and middle-income sub-Saharan African countries face challenges in ensuring optimal mental health care services. Most low-income countries do not have mental health legislation or policies to direct relevant programs, lack appropriately trained mental health personnel, and are constrained by the prevailing public health priority agenda and its effect on funding. The mental health services in South Africa and Nigeria were chosen for comparison as South Africa is a Middle Income (MI) and Nigeria is a Low Middle Income (LMI) country, both being rated as developing countries which have adopted primary health care as the model of care. In South Africa, General Practitioners (GPs) play active roles in offering primary mental health care services such as outpatient care, screening, follow-up, and referral. Secondary levels of mental health care located in regional hospitals, and tertiary level institutions provide specialized services at designated psychiatric hospitals (Saraceno, Van Ommeren, Batniji, Cohen, Gureje, Mahoney, Srihedar, & Underhill, 2007; Burns, 2008; Mkize, Green-Thompson, Ramdass, Mhlaluka, Dlamini, & Walker 2004).

South Africa currently uses treatment protocols for mental health disorders in response to the end to promote mental health of persons with mental disorders, as well as a practical guide for primary care providers to be able to manage common psychiatric disorders across district and community levels. The South African treatment protocols assist non-psychiatrist clinicians such as medical officers and psychiatric nurses who are involved with day-to-day care and management of mental health users in outreach clinics and health centers in the community. In spite of the integration of mental health services in primary health care and standardized treatment procedures, South Africa faces the challenges of limited mental health human resources, low ranking of mental health as a public health priority, the biomedical orientation of health care, poverty, lack of infrastructure, and poor information systems to monitor mental health service delivery, amongst other factors, which poses difficulties in realizing an improved mental health care access (Burns, King, & Saloojees, 2007; WHO-AIMS, 2007; Lund, 2007; Mkhize & Kometsi, 2008).

Nigeria has no treatment protocols and there is no uniform standard of care and management of patients across big hospitals. Many reasons have been advanced for failure of the primary mental health care program in Nigeria, including the fact that psychiatric care is only provided at a few large mental hospitals in big cities. Furthermore, there is a lack of human resources and difficulty in retaining staff, particularly in rural areas as well as poor referral or state funding of mental health service. While both countries operate primary health care systems, South Africa has integrated mental health care services in primary centers in the communities, while Nigeria operates an institutional care model, making mental health services accessible only in big institutions located in a few urban centers. Mental health care is provided in a few tertiary facilities that provide both primary and specialist care, none of which have beds for children and adolescents, as well as in a few secondary facilities that have psychiatric units with general physician support, which may not always be functional (Alem, Jacobsson, & Hanlon, 2008; WHO-AIMS, 2006).

South African legislation made provisions for a free mental health care, whereas in Nigeria, services are paid for on an out-of-pocket basis, the goals of NHIS to provide Free Medical Care is focused on how to reduce child and maternal mortality in order to achieve the Millennium Development Goals (MDGs), as such mental health care service coverage in its program is low priority. The number of professionals providing mental health care and issues of human resource training for mental health is highlighted in both countries. South Africa is relatively

well resourced compared to other sub-Saharan countries in regard to mental health personnel, as most middle- and low-income countries have grossly inadequate manpower to deal with mental disorders. In South Africa, mental health professionals work in the private and public sectors. In Nigeria, 95% of professionals who are psychiatrically trained work in tertiary institutions and the other 5% work in non-mental health care facilities. The scarcity of specialist mental health professionals in both countries is a hindrance for the development of primary mental health care (NHIS, 2011; WHO-AIMS, 2006; WHO-AIMS-2007; Lund, 2007; Human Resources for Health Country Profile- Nigeria, 2008; Saxena, 2007).

2.5 CONCLUSION

Chapter 2 dealt with the literature review to gain insight on the findings of other researchers on the topics under the study. Various publications by different authors were consulted. The following knowledge is contained in this chapter:

- Historical overview of care of mental health care users by non-psychiatric trained professional nurses.
- Violence in the workplace.
- Training of mental health staff.

The next chapter 3 focuses on the research methodology of the study.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter explains the research methodology used in the study. A qualitative research method is discussed, as well as the comprehensive phenomenological, exploratory, descriptive and contextual research design chosen for the study. This chapter discusses the required nature characteristics of participants for the study which are outlined in the inclusion criteria, as well as the method used to select the participants. The measures to ensure trustworthiness of data and the way in which the rights of participants have been protected are discussed.

3.2 STUDY SITE

The health care system in the Limpopo Province functions at four (4) levels, namely primary healthcare hospitals, district hospitals, regional hospitals and tertiary hospitals. There are forty one (41) hospitals in the Limpopo Province. Thirty four (34) of these hospitals are district hospitals that provide for patients seen at and referred by primary healthcare clinics. Five (5) of these regional hospitals are meant to accommodate patients seen at and referred by district hospitals. Two (2) of these regional hospitals are tertiary campus hospitals that attend to the healthcare needs of patients seen at and referred by regional hospitals. This arrangement leads to patients from primary healthcare and district hospitals being referred directly to the tertiary hospitals. Tertiary hospitals end up serving patients referred by primary health care, district and regional hospitals.

The study was conducted in a naturally, uncontrolled, real life environment. The study was conducted at Dilokong Hospital of Greater Tubatse Municipality, Sekhukhune District of the Limpopo Province in South Africa. Dilokong Hospital is situated in the deep rural villages of Sekhukhune North of Polokwane City plus or minus 140 Kilometres from Polokwane. The nearest town is Burgersfort which is plus or minus 10 kilometres from Dilokong Hospital. Dilokong Hospital consists of eight (8) wards: maternity, paediatric, tuberculosis, female and male medical, female and male surgical and Tshepo clinic. Mental health care users are admitted at medical wards as there is no psychiatric ward in the hospital. Limpopo Province is having three mental health institutions: Hayani, Thabamoo and Evuxakeni hospital.

3.3 QUALITATIVE RESEARCH METHOD

A qualitative research approach was used in this study. Qualitative research is an approach which describes and analyses the human experiences. Welman, Kruger and Mitchell (2005) further describe a qualitative research method as an approach aimed at establishing the socially constructed nature of reality, at stressing what relationship between the researcher and the object of the study has, and at emphasising the subjectivity nature of the enquiry. The qualitative research method has been chosen because it seeks to understand the meaning and interpretation of human experience that is given to the situations or events. The qualitative research approach had been used to understand the experiences of non psychiatric trained professional nurses with regard to care of mental health care users. The researcher used semi-structured interviews with the purpose of enhancing the relationship with the non psychiatric trained professional nurses while collecting data about the care of mental health care users (Hansen, 2006. Welman, Kruger & Mitchell, 2005).

The participants were encouraged to talk as freely as possible. To ensure an in-depth expression, the researcher allowed each participant to tell her experiences without any interference. Semi-structured interviews were used as data collection method with the intention of understanding participant's lived experience in their own words. The researcher started each interview by introducing herself and the topic for discussion to establish rapport with the participants. The researcher listened attentively to the participants. Data were collected from verbal and non-verbal communication. In this study the participants shared with the researcher their experiences regarding the care of mental health care users.

3.4 RESEARCH DESIGN

A phenomenological, exploratory, descriptive and contextual design was used in this study in order to explore the experiences of non psychiatric trained professional nurses with regard to care of mental health care users at Sekhukhune District Dilokong Hospital Limpopo Hospital. Participants were given the opportunity to describe how they care for mental health care users at Dilokong Hospital Sekhukhune District in the Limpopo Province.

Phenomenological research design

Phenomenology is a methodological design that is interested in people's experience with regard to the phenomenon under study and how they interpret their experiences. Welman et al. (2005) further describe the aim of a phenomenological research design to focus on the

understanding of the social and psychological phenomena from the perspective of the people who are part of the phenomena. In this study, the researcher aimed at exploring and describing the experiences of non psychiatric trained professional nurses with regard to care of mental health care users at Dilokong Hospital Sekhukhune District in Limpopo Province. The researcher also questioned non psychiatric trained professional nurses to interpret their experiences with regard to care of mental health care users (Hansen, 2006).

Explorative research design

An exploratory research design aims at identifying the ideas and assumptions behind the phenomenon that have been previously described. The design explores the concept in-depth in as loose and semi-structured way as possible to arrive at a description of an experience. The researcher asked a central question: **What are your experiences with regard to care of mental health care users here in Dilokong Hospital Medical Wards?** In order to explore in-depth ideas that non psychiatric trained professional nurses held about the care of mental health care users. The researcher used listening, reflecting and probing skills after each response from non psychiatric trained professional nurse in order to explore the concept in detail. The researcher led the interview and encouraged the respondents by non-verbal means such as nodding the head (to indicate interest). Communication techniques such as clarification, reflection, paraphrasing, questioning, maintaining eye contact and summarizing were used (Brink, van der Walt & van Rensburg, 2012). The researcher tactfully probed the participants in order to obtain more information in a specific area of the interview. After the participants had finished expressing their thoughts, the researcher asked the participants more specific questions for thorough exploration of the facts stated.

The researcher used probing as a communication skill along with open-ended questioning and tracking for clarification (Brink, van der Walt & Wood, 2012). Tracking allows non-psychiatric trained professional nurse to say in her own words and show understanding of what she said. A reflective summary question was asked in order to reach reflective summary, field notes were written and the researcher repeated what was written in the field notes to the participants to confirm whether what was written was what the participants had said (Polit & Beck, 2012). The researcher maintained non-judgemental attitude throughout the interviews with the participants. All interview sessions were recorded verbatim on an audiotape recorder.

By using listening skills, the researcher was able to maintain continuous interaction with the participants and obtained clarity and meaning about phenomena under study. The researcher followed up with questions about the participants' comments in order to gain more clarity and meaning. The researcher repeated some key words used by participants with the purpose of stimulating them to supply more information (Gerrish & Lacey, 2006).

Descriptive research design

A descriptive design aims at gaining new facts about the situations, people's activities or frequency with which certain events occur. The purpose is to provide a picture of situations as they naturally happen without the researcher making any attempts to influence the responses of participants. The researcher maintained non-judgemental attitude throughout the interviews with the participants. The participants were given an opportunity to describe their experiences with regard to care of mental health care users at Dilokong Hospital Sekhukhune District in Limpopo Province (Gerrish & Lacey, 2006).

3.5 POPULATION AND SAMPLING

A population is the total number of entities sharing the same characteristics and consists of individuals, group, organisations, human products and events or the conditions to which they are exposed. The population is chosen in close relation to the study problem. The population of this study was all non-psychiatric trained professional nurses who provided care to MHCU's working at Dilokong Hospital Medical Wards both female and male (Welman et al., 2005).

Sampling is defined as the method of selecting a minor section of the population. This study used non-probability, purposive and convenience sampling methods to select the participants. Non-probability refers to the odds of selecting a particular individual that are known, since the researcher does not know either the population size or the members of the population. Purposive sampling is based on the judgement of the researcher, since the sample is composed of elements that contain characteristics that are of interest for the phenomenon studied (de Vos, Strydom, Fouche & Delport, 2005).

Convenience sampling involves the choice of readily available participants for the study. While selecting the sample, the researcher held a meeting with non psychiatric trained professional nurses in both medical wards at Dilokong Hospital of Sekhukhune District. The researcher explained the aim of the study to the CEO, Nurse Manager and In charge of the

medical wards and asked for the staff establishment of both female and male medical ward. The staff establishment was then studied to check who were meeting the selection criteria of the study. The non-psychiatric trained professional nurses who met the selection criteria were then selected based on their availability. The non psychiatric trained professional nurses who were purposively and conveniently selected from the staff establishment were interviewed in private cubicles and they represented female and male medical ward, where six (6) from each ward were included until data saturation was reached (Brink, Van der Walt & Van Rensburg, 2012).

Inclusion criteria

Non-psychiatric trained professional nurses; with more than two years' experience in the hospital setting and working in the medical wards were included in the study, because these professional nurses are the once caring for mental health care users. In this study inclusion criteria created, based on the judgement of the researcher and used to deliberately include criteria-specific participants. The study included all non-psychiatric trained professional nurses caring for mental health care users working at Dilokong Hospital. Non-psychiatric trained professional nurses were interviewed in English only because in nursing they were trained in English as medium of instruction since there is no vernacular consent form. Data was saturated with the 12th participant.

Exclusion criteria

The study excluded all psychiatric trained professional nurses working in female and male medical ward caring for mental health care users.

3.6 PREPARATION FOR DATA COLLECTION

Medunsa Research Ethics Committee (MREC) gave clearance for the study to be conducted. The Limpopo Department of Health Research Ethical Committee gave permission for the study to be conducted at Dilokong Hospital of Sekhukhune District in Limpopo Province. The researcher first contacted the hospital manager with the aim of building rapport, to discuss the involvement of the participants in the study and to inform the manager about planned dates for collection of data. The researcher also defined the purpose of the study and presented to an approval letter from the MREC and the permission letter to collect data from the Limpopo from the Limpopo Department of Health Research Ethics Committee. Permission to approach the units and the professional nurses was granted by the nurse

manager. The researcher introduced herself to the nurse managers and requested the medical wards staff establishment that was studied, to identify the non-psychiatric trained professional nurses who met the selection criteria. A private cubicle with minimum noise in both wards was then arranged for the interviews to take place.

3.7 DATA COLLECTION

Data were collected using the semi-structured face-to-face interviews with guide all the participants who met the inclusion criteria. Semi-structured face-to-face interviews are interviews that are conducted without any set research questions but only the central question. Semi-structured face-to-face interviews were chosen because the interest required an understanding of the experiences of non-psychiatric trained professional nurses about the care of mental health care users by exploring one central question more thoroughly. Therefore, after the participants' first responses the researcher asked clarity seeking questions. Semi-structured interviews allow a researcher to explore, and the participants to describe issues pertaining to the phenomenon under study (Hansen, 2006. de Vos et al., 2006).

During the semi-structured face-to-face interviews, the researcher avoided asking leading questions. The central question was asked to all the participants during the semi-structured face-to-face interviews: **“Will you kindly describe your experiences with regard to care of mental health care users at this Hospital?”** The researcher led the interview and encouraged the respondents by non-verbal means such as nodding the head (to indicate interest). Communication techniques such as clarification, reflection, paraphrasing, questioning, maintaining eye contact and summarizing were used (Brink, van der Walt & van Rensburg, 2012). The researcher tactfully probed the participants in order to obtain more information in a specific area of the interview. After the participants had finished expressing their thoughts, the researcher asked the participants more specific questions for thorough exploration of the facts stated.

The researcher confirmed the quality of data by using listening, reflecting and probing skills after each response of the professional nurse. A researcher is expected to have good listening skills for obtaining quality information and for gaining a thorough understanding during an interview. The researcher showed interest in the participants by using responses, such as

“mmm” and “okay”, to maintain interaction. The researcher repeated some key words from the participants with the purpose of stimulating them to give more information. For example:

“You said MHCUs run away from the ward and you are responsible for following them, could you kindly elaborate?” Probing persuades participants to supply more information about the phenomenon under study. The researcher probed with questions about the participants’ comments in order to gain more clarity and meaning (Brink et al., 2010).

Interviews continued until data saturation was reached with twelve (12) participants. The interviews were conducted on different days for a period of a week during which twelve non-psychiatric trained professional nurses took part: two males and ten females were interviewed. Gender in the study was dominated by the female nurses. It was due to the hospital units that only had two (2) male and ten (10) female nurses who had consented to participating in the study. Data were audio recorded and field notes were captured in a notebook.

3.7.1 COMMUNICATION TECHNIQUES

In this study, the following communication techniques, according to De Vos, et al (2005) were used during the semi-structured interviews:

3.7.1.1 Encouragement

The participants were encouraged to pursue a line of thought. In this study, the researcher encouraged the non-psychiatric trained professional nurses to elaborate on their experiences about the phenomenon.

3.7.1.2 Listening

A researcher is expected to have good listening skills. The non-psychiatric trained professional nurses were given the opportunity to talk and describe their experiences without interference. The researcher also observed non-verbal and facial expressions.

3.7.1.3 Clarification

Clarification embraces the method that seeks further explanation of unclear statements. The researcher asked follow-up questions, “Could you tell me more about...?” to gain more insight and a better understanding of the responses provided.

3.7.1.4 Paraphrasing

Paraphrasing involves a verbal response when a researcher would repeat the essence of what participants are saying to confirm that the statements are correctly understood. The researcher tried to obtain accurate meaning by asking the non-psychiatric trained professional nurses the same questions in a different manner, using the same words that the participants used.

3.7.1.5. Probing

This is the technique used to persuade a participant to provide information about the issue under discussion. This assisted the researcher to get a detailed response to a question, to increase the richness of the data being obtained, and to give clues to the non-psychiatric trained professional nurses about the level of response that is desired.

- **Challenging**

The researcher explored more information from non-psychiatric trained professional nurses as a way to prove validity of the information given.

- **Acknowledging**

The researcher listened attentively to non-psychiatric trained professional nurses and confirmed it by sometimes repeating after them what they had said.

- **Linking**

The researcher linked the responses to the information desired to obtain what is already known about the phenomenon.

- **Direct Questioning**

The researcher obtained more information by asking non-psychiatric trained professional nurses questions that were directly linked to the problem under discussion.

3.8 DATA ANALYSIS

Tesch's open coding method of qualitative data analysis was used in this study. Open coding is the part of analysis that pertains specifically to the naming and categorising of a

phenomenon by close examination of the collected data. During open coding, data were condensed into discrete parts, closely examined, and compared for similarities and differences. Questions were asked about the phenomenon as it had been reflected in the data. Audio recorded data were transcribed verbatim on paper. The transcripts were organised into fields and clearly labelled by numbers and markers (Cresswell, 2011). Tesch's open coding technique was used by following these steps during data analysis:

- The researcher obtained a sense of the comprehensive study by reading through the transcripts carefully. Ideas that came to mind were jotted down;
- The researcher selected one interview, for example the shortest, the one at the top of the pile or the most interesting one and examined it while asking: "What is this about?" and thinking about the underlying meaning of information. Again, any thoughts that were coming to mind were jotted down in the margin;
- When the researcher had completed this task for several participants, a list of all the topics was compiled. Similar topics were clustered together and formed into columns that were arranged into major topics' unique topics and irrelevant issues;
- The researcher took the list and returned to the data. The topics were abbreviated as codes and the codes were written next to the appropriate segments of the text. The researcher assessed this preliminary organising scheme to establish whether new categories and codes were emerging;
- The researcher found the most descriptive wording for the topics and turned them into categories. The researcher endeavoured to reduce the composite list of categories by grouping together topics that had a specific focus in common. Lines were drawn between categories to show interrelationships;
- The researcher made a final decision about the abbreviations for each category and presented the codes alphabetically; and
- The data belonging to each category were assembled in one place and a preliminary analysis was performed.

Audio recorded data were transcribed verbatim on paper. The transcripts were organised into files and clearly marked or labelled by numbers and markers. A careful line-by-line, paragraph-by-paragraph and an entire text reading of all the relevant transcripts was conducted for becoming familiar with the data. The researcher seeks to understand the content of data and language characteristics of the participants. The phrases, lines, sentences

or paragraphs were coded with different colours and numbers with the purpose of searching for similarities, differences, categories, themes, concepts and ideas. General themes or sub-themes were identified with the aim of reducing data into small and manageable sets of themes that facilitated interpretation and writing up of the final report. The researcher then summarized data in a written form and integrated data within each category and themes by using charts and diagrams. Interpretation was connections in relation to one another. The themes were discussed and argued to substantiate a particular point of view, and the point of view was established according to the researcher questions (de Vos et al., 2006).

The researcher made a summary of the themes and sub-themes identified before sending the data to an independent coder. Once the co-coder had completed the independent coding, common themes and sub-themes of the independent coder and the researcher were identified and summarised.

3.9 MEASURES TO ENSURE TRUSTWORTHINESS

The four criteria to ensure trustworthiness as outlined by Lincoln and Guba (as quoted by de Vos et al., 2006) were used to establish the trustworthiness of the study.

3.9.1 Credibility

Credibility deals with the focus of the research that accurately ensures the identification and description of participants, and how well data and the processes of data collection address the focus of the study (Emmelin, quoted by Mothiba, 2005). Credibility was ensured by prolonged engagement in the study for a period of two months in order to capture the realities of the phenomenon. Triangulation was used to ensure credibility, i.e. an audio recorder was used to record the data and field notes were written during the semi-structured interviews. Referential adequacy was also used to ensure credibility; collected data will be stored for future reference and comparison (Babbie & Mouton, 2009).

The researcher sent the transcribed data, field notes and audio recordings to the independent coder who specialised in qualitative research to ensure credibility. A meeting was arranged to reach consensus about the themes and sub-themes that had emerged independently (de Vos et al., 2006).

3.9.2 Dependability

Dependability occurs when the researcher attempts to account for changing conditions in the phenomenon chosen for the study, since an increasingly refined understanding of the setting creates corresponding changes in the design. Dependability was ensured by the use of an inquiry audit when the researcher was using field notes and audio recordings that were kept after data collection for the purpose of conducting an audit. The researcher coded and recoded collected data according to the stepwise replication of Tesch's approach to ensure dependability. The supervisor examined the research product of the raw data, recorded interviews, interpretations, findings and recommendations for amendments to the study (de Vos et al., 2006; Babbie & Mouton, 2009).

3.9.3 Transferability

Transferability is an extent to which the findings of a study can be transferred to other settings or groups. Transferability was ensured by providing a detailed description in Chapter 3 of the research method, research design and of the results of the study for future references by other researchers. Purposive and convenience sampling techniques were used to select the sample with the aim of collecting relevant data (Babbie & Mouton, 2009).

3.9.4 Confirmability

Confirmability occurs when the findings of the research are the product of inquiry and not of the researcher's bias. Confirmability was ensured by the involvement of an experienced independent coder (Appendix H); the use of an audit trail during which the field notes and transcribed data. In this study, raw data comprising of data from tape recorder and field notes were given to the independent coder. (de Vos, 2006). Names of the participants were not used so that the information could not be linked to participants. The audio tape recorder was used for verification. Themes and categories were examined. Conclusions on the findings were supported by literature. Findings and recommendations were examined; and submission of the project to the supervisor for amendments (Babbie & Mouton, 2009).

3.10 REPORTING AND UTILIZATION OF RESULTS

Reporting includes preparation of a written report that contains all portions of a successfully completed research. The format of reporting the research results depends on the nature of the

study and the type of data collected. The research results were reported in textual format, with the summary of themes and sub-themes explained in a table format (Table 0.2). Meetings were arranged with the Department of Health, as well as the nurse manager of the Dilokong Hospital, to present the findings and the recommendations of the study (Gerrish & Lacey, 2006).

3.11 ETHICAL CONSIDERATIONS

The following ethical standards were followed while conducting the study as outlined by Cresswell (2011):

Permission to conduct the study

Ethical clearance to conduct the study was obtained from the Medunsa Research and Ethics Committee (MREC) (Appendix D). Permission to conduct the study was obtained from the Limpopo Department of Health (Appendix F), and from the CEO and the nurse manager of Dilokong Hospital (Appendix G).

Informed consent

Consent means to give approval, to agree in participating to a study or procedure. Informed consent was obtained from the all the participants. Emphasis was placed on giving accurate and complete information in order for the participants to fully comprehend the investigation and, consequently, to be able to make a voluntary decision about their possible participation in the study. The duration of the interview sessions, and the possible advantages and disadvantages to which participants might be exposed to, such as the improvement of the performance assessment process were explained. Participants were informed that they were not under duress to participate and they could withdraw from participating in the study at any time (Heidenthal, 2013; de Vos et al., 2006).

Privacy and confidentiality

Confidentiality is the right to rely on the trust of an individual and to control access to and disclosure of private information entrusted to that individual. Confidentiality stems from a relationship when an individual gives private information to another individual, on condition or with the understanding that the receiving person will not disclose it, or will disclose it to the extent that the individual directs beforehand. The participants were assured that all

collected data would not be disclosed to any unauthorised person without their permission (Gerrish & Lacey, 2006; de Vos et al., 2005).

All collected information is to be stored in a safe place and kept for a period of five years after data analysis and interpretation is completed to maintain confidentiality. Privacy originates from the concepts of individual freedom, autonomy and it involves the ability of an individual to control the release of information that relates to him or herself. The researcher ensured that participants did not mention their names during the interviews by allocating identification numbers to each participant. All the professional nurses were entitled to describe the experiences by expressing their own thoughts after they had signed a consent form (Gerrish & Lacey, 2006).

Principle of autonomy

Autonomy is the capacity for self-determination. The right to self-determination implies that individuals have the right and competence to evaluate available information, to weigh alternatives against one another, and to make their own decisions. Being autonomous, however, is not the same as being respected as an autonomous agent. To respect an autonomous agent is to acknowledge that person's right to make choices and take action based on that person's own values and belief system. The researcher neither withheld information nor offered incorrect information to the participants while recruiting them to participate in the study (Gerrish & Lacey, 2006; De Vos et al., 2006).

Principle of justice

Justice refers to what society owes its individual members in proportion to an individual's needs, contribution and responsibility; the resources available to the society; and the responsibility for the common good of society. The justice ethical principle states that ethical theories should prescribe actions that are fair to the people involved. Gerrish and Lacey (2006) declares that an ethical decision that contains justice within it has a consistent logical basis that supports the decision, which is everyone is entitled to equal access to basic care necessary for living in a human way. The researcher ensured that all participants were treated equally and that the same information was disseminated to all of them (Gerrish & Lacey, 2006).

Principle of beneficence

This principle is also related to the principle of utility, which states that we should attempt to generate the largest ratio of good over evil possible in the world. The principle of beneficence guides the ethical theory to do what is good. The principle of beneficence is a “middle principle” insofar as it is partially dependent for its content on how one defines the concepts of the good and goodness. Participants were assured that they will not be harmed physically and emotionally. The researcher protected the participants from any form of physical and emotional discomfort that emerged from the research study by giving the participants thorough information about the impact of the study (Gerrish & Lacey, 2006; De Vos et al., 2005).

3.12 CONCLUSION

The qualitative research method; and the phenomenological, explorative and descriptive research design were explained. The individual semi-structured face-to-face interviews as a data collecting tool were also explained in detail. The researcher tactfully probed the participants in order to obtain more information in a specific area of the interview. After the participants had finished expressing their thoughts, the researcher asked the participants more specific questions for thorough exploration of the facts stated. Field notes were written during the interviews and these interviews were also audio recorded. Data were analysed according to Tesch’s method of data analysis. The geographical site where the study took place was explained, as well as the processes/steps that were taken for the preparation of data collection. The chapter discussed the elements that ensured trustworthiness, as well as the ethical standards followed while conducting this study. The following chapter 4 discusses the results of the study.

CHAPTER 4

RESEARCH FINDINGS AND LITERATURE CONTROL

4.1 INTRODUCTION

This chapter discusses the findings of data collected from non-psychiatric trained professional nurse's experiences with regard to care of mental health care users in Sekhukhune District, Dilokong Hospital. Semi-structured face-to-face interviews with guide which lasted between 30 min to 40min are explained in this chapter. Analysed data consisted of four (4) themes and nine (9) sub-themes as tabled in table 4.1. Four (4) themes and nine (9) sub-themes emerged from semi-structured interviews, interviewed lasted from 30 to 40 minutes. Themes and sub-themes are discussed in this chapter (Burns & Grove, 2005).

4.2 LITERATURE CONTROL

Table 4.1: Demography

Characteristics	Number
Gender	
Female	10
Male	2
Professional nurses were working in:	
Female medical ward	6
Male medical ward	6
Years of experience in the unit	
Two year's experience in the unit	4
Five years experience in the unit	3
More than ten years in the unit	5

Qualifications	
Degree	0
Diploma	12

Gender

Gender in this study was dominated by female nurses. It was due to the hospital units that only two (2) male and ten (10) female nurses who had consented to participate in the study. In male medical ward only two (2) male nurses' consent to participate in the study.

Professional nurses were working in medical wards:

Professional nurses were selected from all medical wards both Female and Male medical wards at the hospital because MHCU'S are admitted in medical wards. The researcher purposively selected professional nurses from the medical wards and interviewed twelve (12) professional nurses who were not trained in psychiatric nursing and who were conveniently available and who had consented to participate in the study.

Years of experience in the unit

The years of experience were important in the study because the duration of experience on care of mental health care users determined the exposure to MHCU's at this hospital. Five (5) professional nurses who were participating had more than ten year's (10) experience in the ward.

Qualifications

Qualifications in this study was dominated by diploma. All twelve (12) participants had diploma in general nursing. There is no participant with nursing degree.

4.3 DISCUSSION OF RESULTS

Table 4.2: An overview of the main themes and sub- themes, reflecting the experiences of non psychiatric trained professional nurses with regard to the care of mental health care users.

Table 4.2: Themes and sub-themes

Themes	Sub-themes
1. Burnout syndrome due to inadequate knowledge.	<p>1.1 Frustration due to lack of knowledge.</p> <p>1.2 Fear towards aggressive mental health care users.</p>
2. Inadequate knowledge about care of MHCUs.	<p>2.1 Inadequate knowledge regarding admission procedures.</p> <p>2.2 Insufficient knowledge in handling a suicidal mental health care user.</p>
3. Lack of support from hospital authorities.	<p>3.1 No financial compensation and support.</p> <p>3.2 Lack of counselling and emotional support.</p>
4. Aggression and violence from MHCUs.	<p>4.1 Calling for assistance when there is an aggressive and violent mental health care user.</p> <p>4.2 Physical aggression of removing and breaking some of the parts of the ward causing damage in the ward.</p> <p>4.3 Aggressive and violent mental health care users attack and injure other patients and staff.</p>

4.3.1 THEME 1: BURNOUT SYNDROME DUE TO INADEQUATE KNOWLEDGE.

Burnout syndrome is a rising complex phenomenon related to stressful working environment. Studies have shown that nurses working in hospitals are at the highest risk of burnout. Several reasons are to be held responsible for the development of this syndrome, such as the demands of patients, possible hazards in nursing care, the constant fear of error in medicine administration, the heavy workload or time-pressure in trying to provide care for many patients during a work shift, the lack of respect from the public, the dislike of the traditional domination of physicians in the health care system, frequent and unpredictable aggressive

behaviour or violence from patients while on duty, the lack of role clarity, understaffing and lack of support at working environment. Another factor strongly related to the development of burnout syndrome is the type of personality and especially “hardiness” which reflects the individual's relative capacity to remain healthy during strong, repetitive, or long time lasting stressful situations (Polikandrioti, 2009).

Some nurses have come to the point of wondering why they should give their all to the work that is not rewarding. This participant said: “I was not happy with the situation. I thought they did not care, so started wondering why I should care about the hospital and that attitude. Why should / care if people don't care about me ” Burnout is viewed as the exhaustion of physical or emotional strength as a result of prolonged stress or frustration (Felton, 2008). The situation in this institution calls for attention because the consequences of burnout are not only detrimental to psychiatric nurses but also to the institution as a whole. This study has shown some similarities to Felton's (2008) findings: the situation reveals an increase in absenteeism, behavioural changes, expressed by short-temperedness, and chemical abuse shown by daily alcohol drinking (Felton, 2008).

Two sub-themes emerged from the theme: Frustration due to lack of knowledge and fear towards aggressive mental health care users.

4.3.1.1 Sub-theme 1.1: Frustration due to lack of knowledge.

NICE (2011), found that staff members need to have the appropriate skills to work professionally, effectively and compassionately with people with longer term mental health problems.

The study findings revealed that nurses are frustrated due to lack of knowledge on caring for mental health care users. It is evident from the following quotations:

Participant 3: *“We need training in psychiatry because we don't know what to do when the patient is aggressive”*

Participant 9: *“We don't have professional nurses trained in psychiatry MHCUs came from casualty to medical ward and there are some forms which needs to be filled and we just leave the forms as they are because we don't have knowledge on how to fill those forms as they*

need lots of things. If they can train us in psychiatry we will be able to care for them without doubts”.

NICE (2011) also found that staff members need to have the appropriate skills to work professionally, effectively and compassionately with people with longer term mental health problems. All staff should be operating with a recovery orientation and have the relevant training to equip them to deliver evidence base interventions (such as medication management and psychological intervention, etc) appropriate to their qualification and experience level in whichever component of the mental health service they work.

Mavundla (2003) also found that most negative attitudes towards mentally ill were not due to demographic factors like age, rank, and marital status of respondents but were a result of insufficient knowledge that nurses generally have towards mental health care users. In her study, Mavundla also made reference to comprehensive psychiatric training programme that was introduced in South Africa in 1986. The aim of this training was not only to impart knowledge but also to try and improve nurses’ attitudes towards mental illness (Mavundla, 2003).

4.3.1.2 Sub-theme 1.2: Fear towards aggressive mental health care users.

The study reveals that nurses fear to care for an aggressive MHCUs in medical ward. Mixed with medical patients is a challenge especially with the wards because they are meant for medical patients there are oxygen bottles on the wall and MHCUs damaged all. This is highlighted by some participants as follows:

Participant 1: *“During the night MHCUs don’t sleep and you find that there are only three (3) nurses and if the ward is busy is a challenge. We try to close the doors, they able to open it and they even break the door.”*

Participant 10: *“When they come on admission they come being violent and you find that we fear them because you will hear him saying I will beat and injure you. There was once another patient who was admitted during the night and the following day in the morning he went outside and got stones and when he came back, he just came straight to the nurses’ station and he started throwing stones to nurses saying anyone who can come near me I will kill him/her and your children will be orphans.”*

There are factors related to the development of burnout syndrome which includes; the constant fear of error in medicine administration, the heavy workload or time-pressure in trying to provide care for many patients during a work shift, the lack of respect from the public, the dislike of the traditional domination of physicians in the health care system, frequent and unpredictable aggressive behaviour or violence from patients while on duty, the lack of role clarity, understaffing and lack of support at working environment. Another factor strongly related to the development of burnout syndrome is the type of personality and especially “hardiness” which reflects the individual's relative capacity to remain healthy during strong, repetitive, or long time lasting stressful situations (Polikandrioti, 2009).

In 2003, Mavundla conducted a study to assess nurses’ attitudes towards mental illness in a general hospital. The results obtained in Mavundla’s study suggested that very few nurses had positive attitudes towards mentally ill people. They were also found not to be inclined to providing care for such patients. Mavundla found that most negative attitudes towards mentally ill were not due to democratic factors like age, rank, and marital status of respondents but were a result of insufficient knowledge that nurses generally have towards mental health care users. In her study, Mavundla also made reference to comprehensive psychiatric training programme that was introduced in South Africa in 1986. The aim of this training was not only to impart knowledge but also to try and improve nurses’ attitudes towards mental illness.

4.3.2 THEME 2: INADEQUATE KNOWLEDGE ABOUT CARE OF MHCUs.

Staff must be trained in line with more detailed training guidance to be issued by DOH and adequate time must be set aside for training. All staff should be operating with a recovery orientation and have the relevant training to equip them to deliver evidence base interventions (such as medication management and psychological intervention, etc) appropriate to their qualification and experience level in whichever component of the mental health service they work.

Two sub-themes emerged from theme: Lack of knowledge regarding admission procedures, insufficient knowledge in handling a suicidal mental health care user.

4.3.2.1 Sub-theme 2.1: Inadequate knowledge regarding admission procedures.

Non- psychiatric trained professional nurses indicated that they are experiencing problems when coming to admission of MHCU because they are not trained and there some forms which need to be filled by a trained professional nurse in psychiatry like form four (4) and also mental status examination is not done if the trained nurses is not available. This is highlighted by some participants as follows:

Participant 8: *“I will start with the admission as when the patient came to the ward we have to admit him. Sometimes we fail to admit the patient properly because we don’t understand the psychiatric terms and it’s a challenge on psychiatric nursing diagnosis, because some MHCU’s come from OPD with the diagnose (IPD) and we don’t understand its meaning. Mental status examination and form four (4) are not done on admission because there is no trained professional nurse on psychiatry and it will wait for a trained professional nurse when coming back to work from off and the patient’s file will remain empty. The MHCU won’t be admitted using psychiatric format, he/she will be admitted as general patient. If the trained professional nurse on psychiatry is on leave and there is no one available sometimes the patient will be discharged with an incomplete file.”*

Participant 9: *“We don’t have professional nurses trained in psychiatry MHCU’s came from casualty to medical ward and there are some forms which needs to be filled and we just leave the forms as they are because we don’t have knowledge on how to fill those forms as they need lots of things. If they can train us in psychiatry we will be able to care for them without doubts”.*

DOH (2010) conducted a study between October 2009 and February 2010 on mental health nurses working in acute inpatient psychiatric settings in four different NHS trusts based in the South of England and Midlands found that mental health nurses interviewed were very clear that they did both need and want post-registration education and training, specific to acute psychiatric nursing. However, they stressed that any education and training has to be highly relevant to their day-to-day work in acute psychiatric settings. The discussions within the different groups highlighted the fact that different nurses require different types of education and training to suit both their individual needs at different stages of their nursing careers and also to match the needs of working within different nursing teams and with different clients groups (DOH, 2010).

The primary purpose of National Institute for Health and Clinical Excellence (NICE) quality standards is to make it clear what quality care is by providing patients and public with, health and social care professionals, commissioners and service providers with definitions of high quality health and social care professionals in the use of quality standards (NICE, 2011).

4.3.2.2 Sub-theme 2.2: Insufficient knowledge in handling a suicidal mental health care user.

Non-psychiatric trained professional nurses indicated that during night duty only one professional nurses which station in casualty. In medical ward you only find one (1) enrolled nurse and one (1) auxiliary nurse. They call night supervisor only when they need him/her. This is highlighted by some participants as follows:

Participant 11: *“During night duty is only one (1) enrolled nurse and one (1) assistant nurse and they are not trained in psychiatry. There is only two (2) night supers in surgical ward and when MHCU is aggressive you must call night super and you can also find that the night super is not trained in psychiatry also and is a very big challenge,, sometimes when you call she is busy in another ward or went to maternity ward to help there and in that time you don't know what to do”.*

Sandburg, McNeil, and Binder (2006) found that nurses working in some psychiatric inpatient settings are exposed to violence on a daily basis due to the nature of the populations served, the public protection functions of inpatient settings, the culture and demands of the institutional environment, the reduced number of RNs, to lesser-trained mental health workers, and the limitations of the treatment services provided.

In May 2007, the APNA board of Directors commissioned a Task Force on Workplace Violence to examine the scope of the problem and to make recommendations for improving workplace safety. Focus areas for the task force included violence on inpatient settings (including private, forensic, and state funded), outpatient psychiatric settings, and other settings, specifically Emergency Departments (EDs) and home care. A volunteer panel of content experts conducted a comprehensive review of the literature in each of these areas of nursing by searching nursing, medical, and occupational health journals from 1970 to 2008. The task force made recommendations specific to each area and assisted in the development of final report. The findings of the task force are included in three position papers on workplace violence: inpatient and outpatient psychiatric settings, other health care settings

and schools. Initially, workplace violence was broadly defined as any physical assault, threatening behaviour, or verbal abuse occurring in the work setting or outside the workplace but related to work.

4.3.3 Theme 3: LACK OF SUPPORT FROM HOSPITAL AUTHORITIES.

WHO (2005) found strategies to improve retention of staff are essential. Staffs that leave the service are often experienced and fulfil a particular function in a team, which makes them difficult to replace by a newly trained individual. In addition to financial incentives, retention can be improved by providing active support, such as the development and implementation of a mental health promotion strategy for staff and improved motivation, through the provision of training, support, supervision and various other incentives (legal, professional, financial, educational or management).

Two sub-themes emerged from the theme: No financial compensation and support, Lack of counselling and emotional support.

4.3.3.1 Sub-theme 3.1: No financial compensation and support.

The study findings revealed that non-psychiatric trained professional nurses went outside the hospital to fetch MHCUs who absconded and they are not covered to go outside the hospital because they don't receive danger allowance and if they sustained injury, they receive only treatment and off sick days. If something happens to the MHCU it's their responsibility, they are forced to go and fetch the MHCU. This is highlighted by some participants as follows:

Participant 3: *“When the MHCU becomes aggressive we attend to him as nurses whereas we know we are putting ourselves in danger because if we got injured we are not going to be paid. The only thing that you get is free treatment and off sick days depending on your injury. The management said they will pay if you got permanent disability. One day I said because you say you will pay us when the patient has removed one leg or hand or eye it means you are encouraging the MHCUs to beat us.”*

Participant 7: *“They also say no danger allowance because this hospital is not a psychiatric hospital like Groethoek Hospital. You just go to Doctor and given treatment and off sick days but the days are short.”*

Participant 9: *“We don’t get danger allowance and the management says we don’t qualify for it because MHCU’s are admitted for 72 hours assessment and after 72 hours assessment if the patient is still ill they just keep him in the ward. They don’t transfer them to Thabamopo and other psychiatric hospitals. MHCU’s after staying for long in the ward some absconds and they are in danger because they can be beaten by snakes or being hitten by cars and it will be nurses’ problem at the end. Sometimes we receive calls from the community saying we are seeing your patients and we call transport and they release a car and we go and fetch the patient together with securities.”*

Participant 10: *“We don’t receive danger allowance they say we don’t qualify because is not a psychiatric hospital.”*

Participant 12: *“No danger allowance and when we ask management they say this hospital is not made for MHCU’s as they say MHCU’s must be nursed for 72 hours after 72 hours they must be transferred to Groethoek or Thabamopo, but is not practised.”*

Compensation is a system of exchange. Individuals are rewarded with either money or other valuable assets (optional and mandatory benefits), or both in exchange for performing certain functions. This discussion of compensation is confined to the basic exchange of money for time and other benefits, some of which are common and others that are not so common. Compensation can be sorted into direct and indirect categories. Direct compensation is actual money given to a worker and consists of base pay, merit pay, incentive pay, and deferred pay. Indirect compensation does not involve actual money, but is usually associated with monetary value, (i.e., items that would otherwise have to be purchased by the worker her/himself). Indirect compensation includes protection programs such as health and other insurance, pay for time not worked, and other services (Maryland, 2006).

4.3.3.2 Sub-theme 3.2: Lack of counselling and emotional support.

The findings of the study pointed out that those non-psychiatric trained professional nurses when injured by MHCU’s they only receive treatment and off sick days, no counselling. The hospital management says they will get paid when they are totally disabled, if still able to work nothing will be paid. This is highlighted by some participants as follows:

Participant 3: *“We once had one nurse who was beaten by MHCU and sustained fracture on the fingers and she was traumatised and she was treated for free and given free sick offs and*

no counselling from psychologist nothing. We are just treated for free. When MHCU is aggressive we attend to him as nurses whereas we know we are putting ourselves in danger because if we got injured we are not going to be paid. The only thing that you get is free treatment and day offs.”

Participant 5: *“We go to occupational nurse and receive treatment and they give you two (2) weeks sick leave and there is no counselling, and you must explain to your family yourself. The management don’t care about it.”*

Participant 7: *We also receive counselling but no families counselling and no explanation to our relatives, we just tell them ourselves.”*

In many countries, achieving training goals will require a change in the way in which mental health education and training is conducted. There is often a phase lag in which clinical practice moves ahead of the content of training courses, as their curricula tend to change outdated or are not consistent with new models of community based care need to be updated (WHO, 2005a).

4.3.4 THEME 4: AGGRESSION AND VIOLENCE FROM MHCU’s.

Incidents of assault in the workplace have psychological, physical, social and environmental effects. The physical and/or psychological injury that occurs can cost the nurse involved days lost at work, permanent or temporary disability, fear, depression, anxiety, self-doubt, irritability and or disturbed relationships with family and /or work colleagues. In areas of higher incidence of health care workplace assault the environment in which the staff work tends to be fragile. The nursing staff develops feelings of isolation, taking the view that management is unsupportive and uncaring (OSHA, 2008).

The findings of this study pointed out that admitting MHCU’s in medical wards is a challenge to both nurses and medical patients; they are in danger of being injured by MHCU’s. The ward itself is not suitable for admitting MHCU’s because cubicles are made for medicals patients not for MHCU’s and there is no tight security in the ward not even seclusion room where aggressive MHCU can be kept.

Three sub-themes emerged from the theme: Fear to handle an aggressive and violent mental health care user, physical aggression of removing and breaking some of the parts of the ward causing damage in the ward, and aggressive and violent mental health care users attack and injure other patients and staff. This is highlighted by some participants as follows:

4.3.4.1 Sub-theme 4.1: Calling for assistance when there is an aggressive and violent mental health care user.

The study findings revealed that nurses' fear to handle aggressive and violent MHCU and securities are called time and again to come and help nurses when there is an aggressive MHCU. This is highlighted by some participants as follows:

Participant 7: *“We call securities from the gate for man power to hold the patient and we don't restrain him because is not allowed. If the MHCU absconds it is our responsibility to see to it that we call nearest police station and report that there is MHCU who is missing and describe how he looks like and that he is wearing hospital attire. The police will go to patient's home to check if the patient has arrived at home. If the patient is not at home they will search for him around and also got help from the community, they do call hospital and say we are seeing a patient wearing hospital attire. Then we report to the management and we call transport to release the car to go and fetch the patient together with a nurse and securities.”*

Participant 8: *“We call securities to come and help us to take the patient back to his ward.”*

Participant 12: *“I have made a concern asking how about here at medical ward we have security officers at the entrance because if we need them they will be nearer and they said no because at Maandagshoek hospital we use to work without securities. We have to call them from the gate and are far so you must wait for them.”*

Admission Units are areas of higher risk of aggression and consequently assault. Many mental health services are developing smaller *Psychiatric Intensive Care Units* or *High Dependency Units*. These units, usually six-bedded and an annex of the admission ward, provide observation and treatment of patients for whom management on an acute ward is not possible. These units have higher nurse/patient ratios and are proven to have a positive effect on reducing the incidence of violence and aggression with a resultant reduction in the number of assaults against nurses (Royal College of Psychiatrists, Management of Violence in Mental Health Settings, 2006).

Love and Morrison (2013) noted in their white paper on workplace violence that staff training programs in hospitals should include how to remain safe in a hostage situation. Although hostage taking situations in health care are rare, they can be lethal. It is generally accepted

that education and social support should be available for staff after they experience inpatient violence. Often security is not present in outpatient clinics, so mental health staff is vulnerable. Repeatedly violent patients in outpatient psychiatric units are more likely to assault than fellow patients.

4.3.4.2 Sub-theme 4.2: Physical aggression of removing and breaking some of the parts of the ward causing damage in the ward.

The study findings revealed that aggressive MHCUs damage the ward by removing and breaking toilets, windows and basins. This is highlighted by some participants as follows:

Participant 3: *“They say MHCUs must be admitted for 72 hours for assessment but here they stay more than 72 hours. There is one patient who has been admitted since last year is almost a year now and the hospital management is saying nothing about her and we call her hospital child. She is not responding to any treatment and sometimes she became aggressive and breaks windows damage everything in the ward and even stole nurse’s phone and money at nurse’s station.”*

Participant 9: *“MHCUs after staying for long in the ward some absconds and they are in danger because they can be beaten by snakes or being hitten by cars and it will be nurses’ problem at the end. Sometimes we receive calls from the community saying we are seeing your patients and we call transport and they release a car and we go and fetch the patient together with securities.”*

4.3.4.3 Sub-theme 4.3: Aggressive and violent mental health care users attack and injure other patients and staff.

The study findings revealed that aggressive MHCUs attack and injure other patients and staff. This is highlighted by some participants as follows:

Participant 7: *“One night there were two (2) nurses on duty. MHCU just come being aggressive from his ward and find nurses giving treatment in another ward and beats one nurse and falls down and the other nurse saw that my colleague fainted, she ran away and MHCU continue beating that nurse and she sustained fracture on the fingers and she had plaster of parries (POP), now as we talking her one finger is not working”.*

Participant 10: *“When they come on admission they come being violent and you find that we fear them because you will hear him saying I will beat and injure you. There was once*

another patient who was admitted during the night and the following day in the morning he went outside and got stones and when he came back, he just came straight to the nurses' station and he started throwing stones to nurses saying anyone who can come near me I will kill him/her and your children will be orphans."

A serious assault is an assault where the injury sustained results from: - an actual assault by a patient or the application of restraint to a patient where such restraint/ control is deemed to be reasonably necessary to prevent the patient from injuring a nurse or another staff member, or another patient, or a member of the public, or the patient himself / herself or property. And that results in severe injuries necessitating medical treatment or hospitalisation (examples may include broken bones, deep lacerations, internal injuries, loss of teeth, loss of consciousness and post-traumatic stress disorder.), (Survey of Assaults on Psychiatric Nurses, 2006).

A presentation entitled 'An Exploration of Aggression and Violence experienced by Nurses in Mental Health Care Practice in Ireland' informed the Task Force of the issues relating to the management and prevention of violence in the psychiatric setting. The presentation included the categorisation of assaults, identification of locations where assaults most frequently occurred, and training issues for nurses in the management and prevention of violence and the nature of reporting of incidents by nurses.

4.4 CONCLUSION

The care of mental health care users by non psychiatric trained professional nurses is a challenge. Therefore non-psychiatric trained professional nurses supported the need for training of nurses including all categories. The need for a specific psychiatric ward in the hospital or MHCU's to be admitted on their separate ward not to be mixed with medical patients. Non-psychiatric trained professional nurses need a psychiatric doctor in the hospital. To have securities on the entrance of the ward. During night duty to have a trained professional nurse in psychiatry in both medical wards. Danger allowance to all nurses working in medical wards because they are caring for MHCU's and they are in danger. When the nurse is injured to receive counselling together with his/her colleagues', and his/her family to be counselled. Nurses not to go outside the hospital following MHCU's who absconded. Various reasons were given to explain why there is a need for nurses to be trained

on psychiatry. The following chapter 5 discusses the summary, limitations, and recommendations of the study.

CHAPTER 5

SUMMARY, RECOMMENDATIONS, LIMITATIONS AND CONCLUSION

5.1 INTRODUCTION

This chapter provides a summary of the research report, and a description of the recommendations of the study. The recommendations are based on the identified themes. The limitations of the study are also discussed.

5.2 SUMMARY OF THE FINDINGS OF THE STUDY

Aim of the study

The study aimed at exploring and describing the experiences of non-psychiatric trained professional nurses with regard to the care of mental health care users at Dilokong Hospital in Sekhukhune District of Limpopo Province.

Research questions

- What are the experiences of non-psychiatric trained professional nurses regarding care of mental health care users at Dilokong Hospital in the Greater Tubatse Municipality, Sekhukhune District of the Limpopo Province?
- What strategies in place can be used to support the non-psychiatric trained professional nurses caring for mental health care users?

Objectives of the study

The objectives of the study were to:

- Explore the experiences of non- psychiatric trained professional nurses with regard to care of mental health care users at Dilokong Hospital in the Greater Tubatse Municipality, Sekhukhune District of the Limpopo Province.
- Describe the experiences of non-psychiatric trained professional nurses with regard to care for mental health care users at Dilokong Hospital in the Greater Tubatse Municipality, Sekhukhune District of the Limpopo Province.
- Develop strategies to assist non-psychiatric trained professional nurses with regard to care of mental health care users at Dilokong Hospital in the Greater Tubatse Municipality, Sekhukhune District of the Limpopo Province.

Research methodology

The qualitative research approach was used in this study. Qualitative research is a research approach that describes and analyses human experiences (Hansen, 2006). A phenomenological, exploratory and descriptive design was used in this research study in order to explore the experiences of non-psychiatric trained professional nurses with regard to care of mental health care users at Dilokong Hospital in Sekhukhune District of Limpopo Province. The study was conducted at Dilokong Hospital of the Greater Tubatse Municipality, Sekhukhune District of the Limpopo Province.

Findings of the study

The findings of the study indicated the following themes as already discussed in the previous chapter:

THEME 1: BURNOUT SYNDROME DUE TO LACK OF KNOWLEDGE.

Non-psychiatric trained professional nurses' experiences indicated that MHCUs must have their own specific psychiatric ward because in medical ward they care for medical patients. They don't have enough time with MHCUs. They appealing to the Hospital to make available ward for MHCUs, like TB ward because TB patients are not admitted in the medical ward, even with MHCUs they must have their own ward. At least if they can be admitted in the same ward but separate males from females.

THEME 2: LACK OF KNOWLEDGE ABOUT CARE OF MHCUs.

Non-psychiatric trained professional nurses' experiences indicated that they are in dangers because they are not trained in psychiatric nursing. They don't have enough professional nurses trained in psychiatric nursing. MHCUs came from casualty to medical ward and there are some forms which needs to be filled and we just leave the forms as they are because we don't have knowledge on how to fill those forms as they need lots of things. If they can train us in psychiatry we will be able to care for them without doubt.

THEME 3: LACK OF SUPPORT FROM HOSPITAL AUTHORITIES.

Experiences of non-psychiatric trained professional nurses showed that there were many challenges experienced during the care of mental health care users. Such challenges included injuries of nurses as a result of being beaten by MHCUs and given only treatment and off

sick days no counselling, Nurses following MHCU's outside the hospital when they absconded, and no danger allowance for nurses caring for MHCU's. MHCU's are admitted in the medical ward together with medical patients. The hospital management says they will get paid when they are totally disabled, if still able to work nothing will be paid.

THEME 4: AGGRESSION AND VIOLENCE FROM MHCU's.

Non-psychiatric trained professional nurses' experiences indicated that they call securities to come and help them by hand cuffing aggressive MHCU's because they don't have enough knowledge on care of MHCU's. They lock themselves in toilets fearing MHCU'S. They even made a concern asking how about at medical ward they have security officers at the entrance so that when they need them they will be nearer but management said no because at Maandagshoek hospital they used to work without securities. They have to call them from the gate and is far so they must wait for them. They follow MHCU's outside the hospital when they absconded together with the securities.

5.3 RECOMMENDATIONS

The recommendations are based on the themes which have emerged during the interviews with the non-psychiatric trained professional nurses: Non-psychiatric trained professional nurses must be safe at work, Compensation to be awarded to nurses caring for MHCU's, Training of non-psychiatric trained professional nurses, need of specific psychiatric ward, nurses caring for MHCU'S to receive danger allowance, also to have securities in the entrance of the ward.

5.3.1 Non-psychiatric trained professional nurses must be safe at work

- The guidelines on an Occupational Health Safety and Welfare service for Health Service Staff, particularly those relevant to incidents of assaults in the workplace, should be implemented in full and the provision of appropriate services and supports as required should be made available by Occupational Health Departments.
- Training for safe working practice should be implemented for non-psychiatric trained professional nurses in all mental health facilities with particular attention being paid to students or less experienced staff.
- The curriculum for non-psychiatric trained professional nurses should include both instruction and hands-on techniques for safe working practices, with the course content being based on the level of risk of violence in each type of mental facility.

- Non-psychiatric trained professional nurses should be instructed in interventions including verbal skills, self-protection skills and physical interventions.
- Management should be instructed in threat assessment and incident management.
- Ongoing in-service training should be made available to non-psychiatric trained professional nurses to continuously update skills to enable them to eliminate or control incidents of assault.
- Discussion should be initiated with appropriate bodies to standardise training courses and to accredit qualifications of those conducting or partaking in such courses.
- A forum should be established to examine procedures for reporting and collecting data on incidents of assault with a view to making available standard data in respect of all mental health facilities.

This is supported by Dorothy Orem's theory of self-care deficit because non-psychiatric trained professional nurses are not safe as they are caring for aggressive MHCUs without the knowledge of care for MHCUs.

5.3.2 Compensation to be awarded to nurses caring for MHCUs.

- Non-psychiatric trained professional nurses to receive danger allowance.
- Non-psychiatric trained professional nurses to receive counselling together with their colleagues and family members.
- A compensation scheme to be introduced as outlined for nurses injured as a result of serious assaults which will provide a lump sum in respect of pain and suffering and out of pocket expenses, this payment not to include loss of earnings.
- The current compensation scheme, the 'Revised Serious Physical Assault Scheme' (5/6 scheme), for nurses injured as a result of serious assault be continued.
- The scheme to be a "no fault", non-statutory scheme.

5.3.3 Training of non-psychiatric trained professional nurses and enrolled nurses in psychiatry.

- WHO, 2005a also found that there is a need for training general health care staff in basic mental health competencies, to enable them to detect mental disorders, provide basic care and refer complex cases to specialist services; The need to train mental health specialists to work collaboratively with general health workers, and to provide

them with supervision and support. Staff morale and burnout are important areas to consider in planning for mental health services. Staff often experience burnout because of factors specifically associated with mental health care, particularly when they are “low” in the clinical hierarchy, have the most face-to-face contact with service users, and little say in the nature and organization of their work. Nevertheless, for many people the stress of mental health work can be challenging and provides an opportunity for rewards, as clinicians see improvement in their clients and in the effectiveness of their services (WHO, 2005a).

- The pre-implementation training should include an aspect of motivating the non-psychiatric trained professional nurses to care effectively for mental health care users (Van der Wagen, 2007). Van der Wagen (2007) further states that the purpose of caring for mental health care users should be emphasized during training because nurses are being injured as a result of lack of knowledge regarding the care of mental health care users. Non-psychiatric trained professional nurses should be trained to care for mental health care users even when they are aggressive and the training programme should be designed to increase an awareness of care of mental health care users. The training could also take place in the form of role playing, when non-psychiatric trained professional nurses play the role of mental health care users to enhance the discussion about the care of mental health care users. It is based on theme 2: Lack of knowledge.
- Non-psychiatric trained professional nurses should be trained before caring for mental health care users. It will lead to reducing the injuries sustained from being beaten by aggressive MHCUs. Glueckert (2011) states that it is important that in-service training should be done continuously in order to revise every aspect that pertains to the care of MHCUs. It is based on theme 2: Lack of knowledge.
- Non-psychiatric trained professional nurses should be engaged in an in-service training that will assist them in caring for MHCUs. The in-service training should focus on the way in which feedback about the care of MHCUs is supplied to afford non-psychiatric trained professional nurses an opportunity to ask questions and to understand the care for MHCUs (Wilkinson, 2010). Swanepoel (2008) outline that the training of feedback skills before conducting care of MHCUs is recommended because feedback is one of the developmental purposes of care of MHCUs for non-psychiatric trained professional nurses that provides an opportunity for discussion and

it can minimise injuries related to aggressive MHCUs. It is based on theme 2: Lack of knowledge.

- Non-psychiatric trained professional nurses should be trained thoroughly to implement the care of MHCUs to enhance consistent process and to increase the productivity of psychiatric trained professional nurses (Roussel, 2012). It is based on theme 2: Lack of knowledge.
- Non-psychiatric trained professional nurses should be trained so that they are empowered to identify and refer serious, as well as common mental disorders, including behavioural and school-related problems, which have been shown to be common at hospital level. Training and support should also be provided to supervisory and other management staff in order to develop a leadership culture that is in tandem with the egalitarian principles of the hospital. It is based on theme 2: Lack of knowledge.
- The need for psychiatric nurses will be great since their command of multiple bodies of knowledge (medical science, the neurobiology of psychiatric disorders, treatment methods and relationship science) situates them as the key players to maintain the connection between psychiatry, medicine, and case management systems (Hanrahan & Sullivan-Marx, 2005). Psychiatric nurses have always been professionals on the direct lines of care who understand both everyday needs and complex medical/psychiatric needs of patients (Rolfe & Cutcliffe, 2005). It is based on theme 2: Lack of knowledge.
- “I am interested in psychiatry. I even applied for study leave for psychiatry long time and they didn’t consider my study leave because they were using favourism in this hospital. What I observed is that staffs are afraid of MHCUs. I worked in Thabamoopo Hospital for three (3) years and I brought the experience to this ward to be able to care for MHCUs. I even tell the Doctor to prescribe some treatment to some of MHCUs because of the experience that I got from Thabamoopo. Since in this hospital there is no competent Doctor for psychiatry and we need a psychiatric Doctor”.

Dorothy Orem’s theory of self-care deficit applies here because non-psychiatric trained professional nurses are not trained in psychiatry.

5.3.4 The need of specific psychiatric ward with a seclusion room

- The ward needs to be a therapeutic space that can help a patient gain control over their general recovery. It should provide a structured therapeutic system of activities on weekdays and weekends alike. The range of activities should include occupational therapies such as art and craft, yoga and quizzes, as well as ordinary simple indoor and outdoor activities such as preparing food, reading in the library, and gardening. Active measures should be taken to enhance patients' physical health including encouraging a healthy diet and exercise, assisting with smoking cessation and addressing substance misuse.
- The layout, design, decoration and ambience provided by the physical surroundings all play a role in fostering a therapeutic environment for both patients and staff. Access to fresh air is vital, as are quiet and private spaces on the ward and in outdoor areas. A good ward should also have appropriate spaces for community in-reach activities. Separate toilets and sleeping accommodation for men and women is also an important standard and a government policy. Guidelines on interior and exterior design could provide a model for how a ward should look. Periodic reviews of the ward environment would be useful, as the ward is not a static place. It is based on sub-theme 4.2: Physical aggression of removing and breaking some of the parts of the ward causing damage in the ward.
- General adult wards should not have more than 18 beds on any one ward. Larger wards can seem institutional and can contribute to patients feeling less safe. Integral to effective treatment and recovery is a good relationship between the patient and the staff, coupled with a tailored approach to the individual's needs and careful planning of their care pathway. This can be more difficult to build and sustain with greater numbers of patients on wards. Smaller wards also permit a more personal and comfortable environment. It is based on sub-theme 4.2: Physical aggression of removing and breaking some of the parts of the ward causing damage in the ward.

5.3.5 Nurses caring for MHCU's to receive danger allowance

- Incentives should be provided and initiative rewarded. Supervision by specialists (e.g. psychiatrists, psychologists) and support for emotional labour should also be provided. Non-psychiatric trained professional nurses are at risk when caring for

MHCU's because anything can happen at any time. They can even get permanent disability. It is based on sub-theme 3.1: No financial compensation and support.

5.3.6 Tight security in the entrance of the wards

- Security staff also requires training in calming and restraint of patients, especially in absence of police. If the patient requires more security than can be offered by the nursing staff and security on duty, or if help is needed to apply or adjust restraints. Note: need to arrange an agreement with EMRS to provide this service. If you are frightened or made nervous by a patient, if possible, have another staff stay with you when you talk to him. You will feel calmer and more reassured and this will have a calming effect on the patient. If you are concerned for the safety of the patients or staff, it is permissible in an emergency to apply restraints prior to the arrival of the medical officer on duty. It is based on sub-theme 4.1: Fear to handle an aggressive and violent mental care user.
- Safety is especially pertinent to nursing practice due to safety issues surrounding restraint and because error/mortality can be tied to the nurse/patient ratios. As scrutiny of safety and error continue, nurses have assumed a key role in designing studies on the relationship of nursing, staffing and patient safety. But they must also maintain a role consistent with their direct care position and anticipate systems error and act before a flawed process plays out. In the inpatient arena, psychiatric nurses, as managers of the milieu, must move the safety agenda beyond reducing restraint to a studied approach of how to create safe units, both physical and psychological, and devise the measurement of key systems/staffing factors that result in reductions in restraint, violence, and other threats to patient safety (Johnson & Delaney, in review; Delaney, 2006). It is based on sub-theme 4.2: Nurses go outside hospital to fetch absconded MHCU's.

5.3.7 Self development

- The hospital management must be the initiator of non-psychiatric trained professional nurses training and the non-psychiatric trained professional nurses could then supplement the training that the hospital has provided.

- Non-psychiatric trained professional nurses should attend workshops that inform them about what to do, and how to care for aggressive MHCU. It is based on theme 3: Lack of support from hospital authorities.
- Hospital authorities to support non-psychiatric trained professional nurses emotionally.

Dorothy Orem's theory of self-care deficit applies as non-psychiatric trained professional nurses are not developed through training.

5.4 LIMITATIONS OF THE STUDY

The study was conducted in one hospital of the Greater Tubatse Municipality in the Sekhukhune District of the Limpopo Province in South Africa. Therefore, the study cannot be generalised to other hospitals in other provinces.

5.5 CONCLUSION

In order to solve the problems associated with care of mental health care users by non psychiatric trained professional nurses, the training of non-psychiatric trained professional nurses, including enrolled nurses, and enrolled nursing assistants is regarded as the fundamental principle for caring mental health care users. The hospital management and nurse managers are urged to arrange study leaves and workshops about the care of mental health care users. It is important to emphasise the need for supplying feedback about the workshops. The ethical and legal regulations are also recommended to correct and direct nurse managers and non-psychiatric trained professional nurses about issues of mental health care users. The CEO and nurse managers are always urged to regard the care of mental health care users as a step towards the productivity of the hospital. As such, the nurse manager, in collaboration with human development training, must implement training programmes for the non-psychiatric trained professional nurses.

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APPENDIX A: INTERVIEW GUIDE

CENTRAL QUESTION

Describe to me in details all your experiences as non-psychiatric trained professional nurse when caring for mental health care users?

TENTATIVE PROBING / FOLLOW UP QUESTIONS

1. What do you mean when you say that “I’m appealing that the Province must open a psychiatric hospital around Sekhukhune so that we can send MHCU’s there?”
2. Do I understand you correctly when you say that *“you need training in psychiatry because you don’t know what to do when the patient is aggressive?”*
3. Since you are not trained in psychiatry what coping mechanisms have you used when caring for MHCU’s?
4. Since you are not trained in psychiatry is there any other information you would like to share with me?

APPENDIX B: EXAMPLE OF AN INTERVIEW

Title: The experiences of non-psychiatric trained professional nurses with regard to the care of mental health care users in Sekhukhune District, Limpopo Province.

Date of the interview: 25 April 2014

Place of the interview: Dilokong Hospital Medical Ward

Time of the interview: 15:30

Interviewer : Netshakhuma Nancy

Participant : Participant no. 7

Experience : 5 years

Language : English

Participant walks into the interview room.

Researcher: Good afternoon.

Participant: Good afternoon to you too.

Researcher: How are you this afternoon?

Participant: I am fine and you?

Researcher: I am fine thank you. I am Ms Netshakhuma I am a student at the University of Limpopo. I am here to collect data on the experiences of non-psychiatric trained professional nurses with regard to care of mental health care users. I already know your name and for confidentiality and anonymity I'll address you as participant. No 7. I hope you don't mind.

Participant: *Okay I don't mind.*

Researcher: Mam can you please describe to me in details all your experiences when caring for mental health care users.

Participant: *“Of course. Firstly I don't know about psychiatry because I'm newly appointed at medical ward. I face problems with MHCUs because they break hospital properties and they threaten nurses. They fight each other and if you don't know how to nurse those patients are difficult because I don't know how to manage them “hey”. They also fight nurses and if*

they are many (MHCU) they fights each other but they just fights and no injuries. When we report the matter to the hospital management they said we must assess the patient only for 72 hours because is not a psychiatric hospital and patients stay longer than 72 hours that's we found that is difficult to care for them because they brake everything and when we report it nothing has been done. When we ask the hospital management they say there is no reason to transfer the patient to Thabamooopo Hospital because now the patient is stable meanwhile previously the patient breaks the hospital properties and fights nurses and other patients "eeee". If the patient continue to be aggressive doctors' just add medication for them, for example; injections. They just sedate the patient for long time.

When they fight nurses and we report to the management "hey" they say if the hand is broken and still working no money will be given to that nurse and if the hand is not working at all may be is then that they can pay you. They also say no danger allowance because this hospital is not a psychiatric hospital is not like Groethoek Hospital. You just go to doctor and given medication and free off days until you are fine but the days are too short. We also receive counselling but no family counselling and no explanation to our relatives "mmm" we just tell them ourselves. I'm not covered but I think I'm learning because I'm preparing myself to go to training on psychiatric nursing because I like that ward and MHCU's but I don't have much experience on that because I'm not trained, but I don't have any problem working with them. And when these patients are stable I enjoy working with them."

PAUSE

Researcher: when you ask the patient why he climbed what did he say?

Participant: *"Mmm" he just said he wanted to go home. This hospital is new is not old and is beautiful, but because we admit MHCU's "hey" it has been damaged. We use to have side ward which were used to as private wards but now we no longer having private ward because these MHCU's they have damaged all our side wards. And on these side wards we found that there are four (4) beds and we do admit more than four (4) MHCU's sometimes which forced nurses to put them on other side wards which is not there's and they damage all the side wards. We are having oxygen and suction machines on the walls and side lamp but if you can look "hey" they are all broken. There is nothing good that we can show you as you can see at that ward that we use to admit them there are no doors, glasses everything is damaged. We once have MHCU two (2) months back he climbed in the ceiling and during the night nurses who were working that night didn't saw him when he climbed, "eeee" they*

were just surprised when the ward was full of water and they wanted to see where the water comes, and they found that he stand on top of the tap of the geyser and whole ward was full of water and they saw that the water is from the ceiling. When they try to look, they saw is a patient and that patient falls down. How did that patient climbed up there no one knows and we called maintenance people to come and fix the tap “hey” even now you can go and check the ceiling is no longer the same as old one because they just fixed it.”

Researcher: When you report to the management what did they say?

Participant: “We called them to come and see what is happening and at the end we don’t know where they finish the matter because we didn’t got the report. They just came and see what happened and take history from nurses then they go, “hey” for what they do or talk when they sitted we don’t know. Like these MHCU’s they are having a tendency to run away, you will want him and he will be no were to be found. They run through the hospital fence they jumped the stop nonsense and when they run away we experience the problem of writing a statement why the patient run away and is a very big problem to us nurses because they expect us to write statement on what happened and this hospital is not built in a way that it can also accommodate MHCU’s. “hey” and even if you saw the patient running, you can’t run after him especially when you know that the patient is dangerous because there is no danger allowance and what if the patient injuries you.”

Researcher: When the patient run away who is responsible for following the patient?

Participant: “It is our responsibility because we must see to it that we call police, we look for nearest police and tell then there is a patient missing and we describe him and that he is wearing hospital attire. We ask them to search for him. They will go to patient’s home to check if the patient arrives home and if he arrived they took him back to hospital. If the patient is not at home they help to search for him around here and we also got help from the community they do call hospital and say we are seeing patient with hospital attire then management send hospital car with a nurse and they go and fetch him back to hospital.”

“Like yesterday there was another patient missing since he was discharged as you know these MHCU’s their families don’t want them. He stayed at hospital three (3) after being discharged and when we call his relatives they say they are coming to fetch him and they won’t come. So yesterday he saw that his family is not coming to fetch him, he decided to run away. **How did you saw that he ran away?** We didn’t saw him during tea time and lunch time

so around past one (1) afternoon we received a call from the community telling us we are seeing your patient at the main road to Burgersfort “hey” then we called transport department and they released the car and the security to go and fetch him. When he came back we saw that we are in danger is then that we called his family and forced them to come and fetch him, because if he ran away and the car hit him they will say they want their patient as he was at the hospital.”

PAUSE

Researcher: Thanks. Can you clarify me? What do you mean when you say these patient run they go through the fence as I heard you saying?

Participant: *“Yes. What I mean “you know” they run through the stop nonsense. They just climb the fence. As I’m speaking I’m having a photo of another patient climbing the fence we were lucky because we saw him before he jumped the fence. And we ran and took him before he jumped the fence. It was difficult for us to take him because he was already up there. “Hey” so see we are nurses and in other hand we are security. “Ok”. And when the patient has absconded and sustained injury still nurses we are in danger. “Mmm” look at this door on top there on the glass there is no glass can you believe that we closed MHCU because he was aggressive and he climbed on top there and broke the glass. We were trying to seclude him. “Hey” we are in danger and no one is seeing us. May be God is watching us. As the management said that medical wards we are not working. And we don’t rest because our eyes are always looking at MHCU’s to see ate they still there, are they still safe, what is happening and we are nursing many conditions here in medical and some patients are on Oxygen.”*

Researcher: Thank you mam. You have answered me. Due to the challenges that you have mentioned how do you cope with these challenges.

Participant: *“You know. It is hard. It is very hard. If the patient is aggressive we call securities from the gate for man power and we hold the patient, we don’t restrain him/because is not allowed and then we call doctor on call to prescribe something to sedate that patient. Some patients when we sedate them they just sleep.”*

“Eeeee” now we are having a nurse who have been bitten by MHCU and sustained fracture on fingers and even now her small finger is not working. It was during the night were MHCU just fights them and they were just two (2) because during the night we work being two (2).

He beats one nurse while she was giving treatment and that nurse fall down and the other nurse saw that the other one is fallen down and fainted while was trying to run. She ran and when he saw that the other nurse ran away he then go to beat the one who was fainted and that nurse even have plaster of parries (POP) and even now as we are speaking she never got paid. But now she is healed and working. But looking at what we are nursing here “hey” we do qualify for danger allowance.”

Researcher: Thank you mam. Is there any other information you will like to share with me?

Participant: *“Ja”, at least all nurses nursing MHCU’s must be trained on psychiatric nursing. I need training and danger allowance because I’m at risk because sometimes MHCU’s fights nurses. We need a specific ward for MHCU’s and trained psychiatric nurses to care for MHCU’s.”*

Researcher: Thank you very much I appreciate it.

Participant: *“Thank you.”*

APPENDIX C: CONSENT FORM

UNIVERSITY OF LIMPOPO (Medunsa Campus) ENGLISH CONSENT FORM

Statement concerning participation in a Research Project*.

Name of Project / Study:

The experiences of non-psychiatric trained professional nurses with regard to care of mental health care users in the Sekhukhune district, Limpopo Province

I have read the information and heard the aims and objectives of the proposed study and was provided the opportunity to ask questions and given adequate time to rethink the issue. The aim and objectives of the study are sufficiently clear to me. I have not been pressurized to participate in any way.

I know that sound recordings will be taken of me. I am aware that this material may be used in scientific publications which will be electronically available throughout the world. I consent to this provided that my name and hospital number are not revealed.

I understand that participation in this Study / Project is completely voluntary and that I may withdraw from it at any time and without supplying reasons. This will have no influence on the regular treatment that holds for my condition neither will it influence the care that I receive from my regular doctor.

I know that this Study / Project have been approved by the Medunsa Research Ethics Committee (MREC), University of Limpopo (Medunsa Campus). I am fully aware that the results of this Study / Project* will be used for scientific purposes and may be published. I agree to this, provided my privacy is guaranteed.

I hereby give consent to participate in this Study / Project.

.....

Name of patient/volunteer

.....

Place

.....

Signature of patient or guardian.

.....

Witness

APPENDIX D: APPROVAL LETTER (MEDUNSA RESEARCH ETHICS COMMITTEE)

UNIVERSITY OF LIMPOPO
Medunsa Campus



MEDUNSA RESEARCH & ETHICS COMMITTEE

CLEARANCE CERTIFICATE

MEETING: 09/2013
PROJECT NUMBER: MREC/HS/319/2013: PG

PROJECT:

Title: The experiences of non-psychiatric trained professional nurses with regard to care of mental health care users in Sekhukhune district, Limpopo Province

Researcher: Ms N Netshakhuma
Supervisor: Dr JC Kgole
Co-supervisor: Dr TM Mothiba
Department: Nursing & Human Nutrition
School: Health Sciences
Degree: MCur

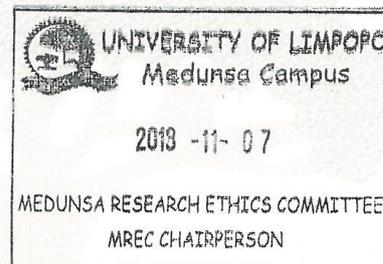
DECISION OF THE COMMITTEE:

MREC approved the project.

DATE: 07 November 2013

pp Mhahmi

PROF GA OGUNBANJO
CHAIRPERSON MREC



The Medunsa Research Ethics Committee (MREC) for Health Research is registered with the US Department of Health and Human Services as an International Organisation (IORG0004319), as an Institutional Review Board (IRB00005122), and functions under a Federal Wide Assurance (FWA00009419)
Expiry date: 11 October 2016

Note:

- i) Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.
- ii) The budget for the research will be considered separately from the protocol. PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.

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**APPENDIX E: PERMISSION TO CONDUCT THE STUDY FROM THE LIMPOPO
DEPARTMENT OF HEALTH**



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquiries: Latif Shamila

Ref:4/2/2

Netshakhuma N
University of Limpopo
Sovenga
0727

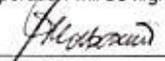
Greetings,

**The Experiences of Non-Psychiatric trained professional nurses with regard to care of Mental Health
Care users in Sekhukhune District, Limpopo Province**

The above matter refers.

1. Permission to conduct the above mentioned study is hereby granted.
2. Kindly be informed that:-
 - Further arrangement should be made with the targeted institutions.
 - In the course of your study there should be no action that disrupts the services.
 - After completion of the study, a copy should be submitted to the Department to serve as a resource.
 - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.

Your cooperation will be highly appreciated.


Head of Department

01/04/2014
Date

18 College Street, Polokwane, 0700, Private Bag x9302, POLOLKWANE, 0700
Tel: (015) 293 6000, Fax: (015) 293 6211/20 Website: <http://www.limpopo.gov.za>

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APPENDIX F: PERMISSION FROM DILOKONG HOSPITAL



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT

SEKHUKHUNE DISTRICT

DILOKONG HOSPITAL

Enq: Ms Rakoma M.S

Tel: 013 214 7265

Fax: 013 214 7201

Private Bag x 9119

DRIEKOP

1129

08 May 2014

Dear Sir/ Madam

PERMISSION TO CONDUCT RESEARCH IN THE INSTITUTION

This letter serves to confirm that Ms Netshakhuma N was granted permission to conduct research in the institution on the 25th and 27th April 2014.

Hoping you find this in order.

Thank you

Yours faithfully

Deputy Manager: Nursing

LIMPOPO PROVINCE
DEPUTY MANAGER: NURSING DILOKONG HOSPITAL
2014-05-08
PRIVATE BAG X9119, DRIEKOP 1129
Date: DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT

INDEPENDENT CODER CERTIFICATE

Qualitative data analysis

Masters degree in Nursing Science

NETSHAKHUMA NANCY

THIS IS TO CERTIFY THAT:

Prof M.N. Jali

Has coded the following qualitative data:

12 Individual interviews and field notes

For the study:

**THE EXPERIENCES OF NON-PSYCHIATRIC TRAINED PROFESSIONAL
NURSES WITH REGARD TO CARE OF MENTAL HEALTH CARE USERS IN
SEKHUKHUNE DISTRICT, LIMPOPO PROVINCE**

I declare that adequate data saturation was achieved as evidenced by repeating themes

PROF MN JALI: 

Revd. Dr. Lutz Ackermann
(Independent Researcher)
198 Berrymead Avenue
Mondeor, 2091
Tel: +27 72 3487010
e-mail: DRLA4 @ directbox.com

24 Oct 2014

TO WHOM IT MAY CONCERN

This is to confirm, that I, Dr Lutz Ackermann, have read the research thesis entitled

“THE EXPERIENCES OF NON-PSYCHIATRIC TRAINED PROFESSIONAL NURSES
WITH REGARD TO CARE OF MENTAL HEALTH CARE USERS
IN THE SEKHUKHUNE DISTRICT, LIMPOPO PROVINCE”

by Miss **NETSHAKHUMA NANCY**

and that I am satisfied with the quality of work she has produced in terms of structuring the document, in terms of style, grammar and spelling. Suggestions for suitable corrections and improvements have been made to the candidate.


(Revd Dr Lutz Ackermann, Mondeor)

