

**NURSES' EXPERIENCES REGARDING IN-PATIENTS WHO ATTEMPT OR  
SUCCEED IN COMMITTING SUICIDE IN A GENERAL HOSPITAL IN GAUTENG,  
SOUTH AFRICA**

by

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submitted in accordance with the requirements

for the degree of

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in

**HEALTH STUDIES**

at the

**UNIVERSITY OF SOUTH AFRICA**

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February 2014

Student number: 3160 564 8

### DECLARATION

I declare that **NURSES' EXPERIENCES REGARDING IN-PATIENTS WHO ATTEMPT OR SUCCEED IN COMMITTING SUICIDE IN A GENERAL HOSPITAL IN GAUTENG, SOUTH AFRICA** is my work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before any other degree at any other institution.

A handwritten signature in black ink, appearing to read 'Mirriam Matandela', is written over a horizontal dotted line.

**SIGNATURE**  
Mirriam Matandela

14 February 2014

**DATE**

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SOUTH AFRICA**

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**ABSTRACT**

The study explored the experiences of nurses regarding in-patients who attempt or succeed in committing suicide in a general hospital. The purpose of the study was to design support guidelines for the nurses who care for patients who attempt or successfully commit suicide whilst admitted at general hospital.

A generic qualitative research approach was followed, using an exploratory and descriptive design. Data was collected through in-depth interviews from a purposive sample of six nurses who met the inclusion criteria. Content data analysis was done.

The research findings revealed five themes. The findings indicate that the working environment was not safe for both the nurses and the patients; confused patients were unpredictable and withheld their intentions of suicide from the nurses. Nurses blamed themselves for in-patient suicide; as some are still living with feelings of guilt. Nurse unit managers provided support to the affected nurses; however debriefing sessions were not given to the affected employees. There were no clear guidelines on management of confused patients. Support guidelines for the nurses are presented in this study.

**Key concepts**

General hospital; in-patient; nurse; suicide nurses' experiences.

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## List of abbreviations

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CEO	Chief Executive Officer
CISD	Critical Incident Stress Debriefing
HIV	Human Immunodeficiency Virus
MEC	Member of Executive Council
PTSD	Post-Traumatic Stress Disorder
SANC	South African Nursing Council
SASH	South African Stress and Health
SAPS	South African Police Services
UK	United Kingdom
UNISA	University of South Africa
USA	United States of America
WHO	World Health Organization

## List of annexures

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- ANNEXURE A Approval of research study by Higher Degrees Committee of the Department of Health Studies, UNISA
- ANNEXURE B Approval of permission to conduct research study by Research and Ethics Committee, Gauteng Province Department of Health
- ANNEXURE C Letter of seeking consent from the study setting
- ANNEXURE D Consent form
- ANNEXURE E Data collection tool

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# CHAPTER 1

## OVERVIEW OF THE STUDY

### 1.1 INTRODUCTION

Suicide is the extremity of a self-inclined, self-destructive act, be it a thought, or an expression or attempt to take one's own life. The degree of lethality, motive, intent and awareness of consequences vary with individuals. Different methods of committing suicide include the use of firearm, hanging, poisoning, gassing, burning and jumping from heights (Uys & Middleton 2010:394).

Suicide is a serious cause of mortality worldwide. It is considered as a psychiatric emergency and the awareness of the seriousness of suicide in society is overlooked. Suicide accounts for 30,000 deaths annually in the United States of America (USA) and more than 5,000 deaths annually in South Africa. The prevalence of suicide in South Africa is on the increase. Etiological factors include social, psychological and physical factors. According to Masango, Rataemane and Motojesi (2008:25), suicide is multi-factorial in nature, with associated risk factors such as demographic factors, psychiatric disorders, terminal or chronic medical conditions and recurrent unresolved psychological stressors.

The researcher's perception is that patients admitted in medical wards are patients that have pathophysiological changes in body systems. These include patients with conditions such as respiratory, cardio-vascular, endocrine, haematological and renal diseases. The conditions are treated with oral and intravenous medication. Some conditions lead to confusion at a later stage. Some patients are admitted with Human Immunodeficiency Virus (HIV) related diseases; are treated for the opportunistic diseases and counselled. Some patients do not accept their HIV status and they resort to suicide.

Suicide is an increasing phenomenon worldwide. According to the World Health Organization (WHO)'s global report on violence and health, one person commits suicide

every 40 seconds, and one suicide attempt is made every 1-3 seconds (WHO 2012). It is estimated that by 2020, these figures may have increased to 1 death every 20 seconds and 1 attempt every 1-2 seconds. According to a study on the profile of suicide in South Africa, suicide accounted for 7.7% of all non-natural deaths in South Africa (Alberdi-Sudupe, Pita-Fernandez, Gomez-Pardinas, Garcia-Fernandez, Martinez-Sande, Lantes-Louzao & Pertega-Diaz 2011:15). Within this percentage Northern Cape accounts 13.4%, Gauteng 10.8%, Eastern Cape 9.9%, KwaZulu-Natal 5.9% and Western Cape 5.0%. Uys and Middleton (2010:395) indicate that Gauteng province is the second leading province in South Africa with regard to high suicide statistics.

According to Uys and Middleton (2010:396), common reactions to patient suicide by health care providers are guilt, anger, self-blame, sadness, fear and feelings of failure. All or some of the mentioned may be experienced; and may be projected onto patients or colleagues. Therefore, a support group meeting for staff should be held when staff availability allows. During this meeting staff should be given an opportunity to discuss their personal feelings about suicide and to explore them. This exercise can create group cohesiveness and a support system.

A study conducted in Taiwan on suicide in a general hospital indicates that in-patient suicides often indicate great patient distress and have devastating effects on survivors and on staff morale (Cheng, Hu & Tseng 2009:111). According to Cheng et al (2009:110), suicide in a general hospital setting received less attention in medical and nursing literature compared to suicide in mental hospital studies.

## **1.2 BACKGROUND TO THE RESEARCH PROBLEM**

Masango et al (2008:26) indicate that attempted suicide is 8 to 10 times higher than the number of successful suicides. In 1997 suicide rate in the USA was 11.4/100 000. This rate slightly declined to 10.7/100,000 in 2000. Between 1993 to 2004 suicides rate among people over the age of 14 was 13/100,000 in England, United Kingdom (UK) and Ireland. In 1999 suicide rate in South Africa was 17/100,000 and is higher than the world average rate of 16/100,000 (Masango et al 2008:25).

Suicide can be committed anywhere, including at home or in hospitals. Patients may be admitted in hospitals for medical conditions but they attempt to commit suicide in different ways and they sustain serious injuries that lead to their death. Most of the time before they die; these patients are assessed and resuscitated by nurses and other health practitioners. When the patients demise following suicide, nurses demonstrate different emotions such as anger, anxiety and sometimes depression. It is worth noting that, irrespective of the setting in which the patient is found the nurse is available to the survivors of suicide.

In-patient suicide is classified as a serious adverse event according to National Core Standards (South Africa 2011). National Core Standards are guidelines that state acceptable operating standards for hospitals. A death that results from a patient committing suicide while admitted for medical conditions in a general hospital is a serious concern for hospital authorities, patient's family members, the community and the media. Following suicide incidents, hospital authorities take accountability; and should give written explanation about the incident to provincial health authorities, including the member of executive council (MEC) for health. In-patient suicide is not only a health matter; it is also a societal and political matter. Due to political and media involvement nursing staff involved in such incidents find themselves under pressure to take responsibility by giving clear explanation of the sequence of events that led to the occurrence of the incident.

According to the researcher's observation patients committing suicide whilst admitted in hospital affect the morale of nurses that care for them prior to the incident; as well as those nurses that resuscitate the affected patients in casualty department. The nurses' morale becomes low due to the experiences that these nurses encounter when these incidents are managed as they are classified as serious adverse events.

Management of serious adverse events include in-depth investigation of the incident. It follows the procedure such as writing of incidents reports, often called statements, file analysis by quality assurance coordinators, clinical managers and nurse managers. The mentioned personnel write the incident reports to assess the clinical status of the patient prior to the incident, and submit preliminary report to central office quality assurance director, to facilitate preliminary investigation by the labour relations officer who will then

interview the nurses that were on duty when the incident occurred. This is followed by an appointment of investigation officer by the central office for intensive investigation of the incidents. The investigating officers interview the nursing personnel involved, assess the environment where the patient was; as well as the number of nursing personnel that were on duty at the time of the occurrence, against the number of patients that were in the unit. Patient safety is also taken into consideration. In-patient suicide is an unnatural death that is reported to the South African Police Services (SAPS) who further request statements from nursing personnel involved through individual interviews. Post-mortem of the deceased, in case of successful suicide is done also by police officers as part of investigation for confirmation of injuries that led to the death of the patient.

Hospital management end up addressing parties such as the media, police, health authorities and politicians with regard to incidents such as attempted suicide or successful patient suicide in hospital. Usually when such serious adverse events occur, hospital management requires written statements from personnel involved, in order to obtain information in preparation for addressing the family of the deceased, reporting the incident to quality assurance directorate.

The researcher's experience is that hospital managers are more concerned about the impact that the adverse event will have on the family, hospital budget, the image of the institution and the perception of the community towards the institution. Very little attention is given to nurses that are involved in those serious adverse events, as people who rush to emergency scenes to fetch these patients, resuscitate them in emergency units if still alive and care for them in intensive care units if admitted. Instead the nurses are expected to write statements and give reasons why the serious adverse events occurred.

Based on the incidents that occurred in a specific general hospital setting, the researcher identified a need for research on experiences of nurses who care for patients who attempt to or successfully commit suicide whilst admitted in hospital.

### **1.3 STATEMENT OF THE RESEARCH PROBLEM**

Nurses are the frontline workers in providing nursing care to patients with acute and chronic medical conditions. They observe patients getting confused and committing suicide using different methods due to complication or deterioration of their conditions.

Common characteristics such as male predominance, more violent methods, and association with depressive disorders, absence without leave, history of previous suicide attempts, emotional difficulties, poor relationships with hospital staff and family and rapid occurrence of suicides in psychiatric or general hospitals are suspicious symptoms (Cheng et al 2008:110).

Nurses' perceptions are that some patients are admitted with medical conditions and they never show signs of depression but eventually they commit suicide. Such incidents leave nurses with unanswered questions as patients never demonstrated signs of mental illness nor confusion. When patients commit suicide nurses are expected to account for the incident.

According to the Hospital Quality Assurance Report during 2008-2012, there were four (1%) of incidents of medical patients who successfully committed suicide by jumping from third the floor where medical wards are situated in the proposed hospital for this study. The mentioned patients had no history of mental illness. The patients were admitted with medical conditions; and their confusion was related to the pathophysiological changes related to the medical conditions as confirmed by laboratory tests. Hence the patients were not transferred to psychiatric institutions but treated in a general hospital. Over the mentioned period four patients died following resuscitation in the casualty unit. These incidents were regarded as serious adverse events whereby the nurses who were involved in the care of these patients had to account. That is, those nurses that cared for the patients in medical units and those that resuscitated the patients in the casualty unit had to write statement about the incidents (Gauteng Provincial Government 2013).

The nurses were expected to write reports regarding the particular suicidal events. The affected nurses were interviewed by nursing management, SAPS, and quality

assurance directorate and labour relations officer; and some eventually went through a disciplinary hearing. Reactions such as guilt, anger, self-blame, sadness, fear, and feelings of professional failure were observed from the affected nurses; and they related to the incidents by absenting themselves from work. Some of the affected nurses were admitted in hospital with depression or stress following these incidents.

Several studies related to suicide have been done in mental health institutions. A study conducted by Powel and colleagues in Oxford on suicide in psychiatric hospital in-patients revealed that the rate of suicide in psychiatric in-patients was 13.7 per 10.000 admissions (Powell, Geddes, Hawton & Deeks 1999:266). Another study conducted by Schlebusch (2005:62) revealed an average suicide rate of 1.4 per 1000 admissions. The patients were unemployed with history of parasuicide and psychiatric hospitalisation. The psychiatric diagnosis of schizophrenia, affective disorder and alcohol dependence were predominating in these patients (Schlebusch 2005: 63). Combs and Rom (2007:4) conducted a study on psychiatric in-patient suicide which indicated that the prevalence of in-patient suicide was between 0,1 and 0,4% of all psychiatric patients. Schizophrenia and affective disorders were the most common diagnoses, and it would be expected that these diagnoses would be heavily represented in patients that commit suicide. Little information is known about the experiences of nurses who care for patients who attempted to commit suicide or successfully committed suicide whilst admitted in general hospitals.

The question was therefore:

“What are the experiences of nurses regarding patients who attempt to commit suicide or successfully commit suicide whilst admitted in a general hospital?”

#### **1.4 RESEARCH PURPOSE**

The purpose of the study was to design support guidelines for the nurses who care for patients who attempt or successfully commit suicide whilst admitted at general hospital.

## **1.5 RESEARCH OBJECTIVES**

The objectives for this study were to

- explore the experiences of nurses regarding incidents of patients committing suicide whilst admitted in a general hospital
- describe the effects of suicide events on nurses caring for patients who attempted or successfully committed suicide
- design support guidelines for the nurses who care for patients who commit suicide whilst admitted in hospital

## **1.6 SIGNIFICANCE OF THE STUDY**

The findings of this study will assist nurse managers, hospital authorities and Gauteng Department of Health to be aware of and understand the experiences of nurses who are involved in the incidents of patients who attempt to commit suicide or successfully commit suicide whilst admitted in hospital. The support guidelines developed from this study will help the institution to manage and support the nurses affected by such incidents. The findings of this study will help authorities to empower the nursing staff on dealing with in-patient suicide and to develop a better approach to management of such serious adverse events.

The study will also help hospital authorities to strengthen Employee Assistance Programmes for nurses who experience such serious adverse events.

## **1.7 DEFINITION OF CONCEPTS**

A concept is a complex mental formulation of experience. Concepts are major component of theory and convey the abstract ideas within a theory (Chinn & Krammer 2008:294). For the purpose of this study, the following concepts are defined:

### **1.7.1 Experience**

Experience is a practical contact with observation of facts or events (Oxford Dictionary 2006:261). Personal experience is the knowledge that comes from being personally involved in an event, situation, or circumstance (Burns & Grove 2009:10).

In this study experience shall mean the events that have taken place within the knowledge of an individual nurse when caring for patients who attempted to commit or committed suicide successfully either during a particular period or generally.

### **1.7.2 General hospital**

A hospital is a licensed establishment primarily engaged in providing diagnostic and medical treatment (both surgical and non-surgical) to patients with a wide variety of medical conditions. It provides other services such as outpatient services, diagnostic X-ray, clinical laboratory services and pharmacy services that are used mostly by internal patients but also by outside patients (National Health Data:2013). A hospital is further referred to as a health care institution providing patient treatment by specialised staff and equipment. A general hospital is one which is set up to deal with many kinds of diseases and injury; and normally has an emergency department to deal with immediate and urgent threats to health (<http://en.wikipedia.org/wiki/>).

In this study a general hospital shall mean a non-psychiatric district hospital situated in Gauteng Province and admits patients with general medical-surgical conditions, including those who attempted suicide and those who successfully committed suicide whilst still admitted in hospital.

### **1.7.3 In-patients**

Patients admitted in hospital for medical conditions that need medical investigations, treatment and nursing care. In-patients in this study refer to those no-psychiatric patients who attempted or successfully committed suicide whilst admitted in a general hospital.

#### **1.7.4 Nurse**

A nurse is a licensed person who is registered with the South African Nursing Council (SANC) to practice nursing, based on completion of a recognised education and training programme to nurture, assist and treat the client, who can be an individual, family or group, sick or well, in the performance of those activities that contribute to the attainment or maintenance of health, to optimal recovery and rehabilitation or to a peaceful, dignified death (South Africa 2005).

In this study a nurse shall mean all categories of nurses who had an experience of caring for patients who committed suicide whilst admitted in hospital.

#### **1.7.5 Suicide**

Suicide is a self-destructive action taken by people who have decided an end to their lives (Du Toit & Van Staden 2009:217). In this study suicide shall mean dying from intentionally hanging or jumping through a window from higher floor of the hospital building. Attempted suicide is a non-fatal self-directed potential injurious behaviour with any intent to die as a result of behaviour; suicide attempt may or may not result in injury (Uys & Middleton 2010:397).

In this study shall mean a medical patient trying to commit suicide but failing to successfully kill himself whilst admitted in general hospital for medical illness.

### **1.8 THEORETICAL FOUNDATIONS OF THE STUDY**

Qualitative research is grounded in a naturalistic paradigm whereby the researcher assumes that reality is not a fixed entity but rather a construction of individuals participating in the research. It offers the opportunity to focus on finding answers to questions centred on social experience, how it is created and how it gives meaning to human life (Streubert Speziale & Carpenter 2007:3). The findings of this study will reflect the experiences of those nurses that participated in this study.

An assumption is a statement that is taken for granted or considered to be true, even though it has not been scientifically tested (Burns & Grove 2009:40). The assumptions of this study were as follows:

### **1.8.1 Metatheoretical assumptions**

Metatheoretical assumptions are assumptions regarding reality underlying the study. The metatheoretical assumption of this study was that nurses present with different reactions when the medical patients they care for attempt or successfully commit suicide whilst still admitted in a general hospital.

### **1.8.2 Methodological assumptions**

Methodological assumptions of qualitative research means that the use of naturalistic methods of inquiry attempt to deal with the issue of human complexity by exploring it directly. Researchers emphasise complexity of humans, their ability to shape and create their own experiences and the idea that truth is composite of realities (Polit & Beck 2008:17).

In this study the methodological assumption was that the generic qualitative research is based on a naturalistic approach that seeks to understand phenomena in a real world setting and, in general. The researcher does not attempt to manipulate the phenomenon of interest.

### **1.8.3 Theoretical assumptions**

Theoretic assumptions are those basic givens or accepted truths that are fundamental to theoretic reasoning (Chinn & Kramer 2008:211).

The theoretical assumptions of this study were that:

- Depressed patients may attempt suicide as they appear to be recovering from their depression.

- Suicide attempt can cause a long standing depression to disappear especially if it fulfils the patient's needs for punishment.
- Suicide is used as an excuse for punishment, and represents aggression, disappointment or anger. Patients who attempt or successfully commit suicide have a self-directed instinct.
- Nurses do not suspect that patients admitted in general hospital with medical condition can commit suicide.
- Nurses blame themselves for in-patient suicide.

## **1.9 RESEARCH METHODOLOGY**

A qualitative research paradigm was followed. Qualitative research involves naturalistic methods of inquiry in an attempt to deal with the issue of human complexity by exploring it directly (Polit & Beck 2008:17). Qualitative research paradigm was relevant because the study took place in a naturalistic environment which is a general hospital. Nurses were included directly as the participants through whom information was gathered. The researcher believed that there are multiple realities related to experiences of nurses regarding in-patient suicide in general hospital.

## **1.10 RESEARCH DESIGN**

An exploratory and descriptive design was used (Polit & Beck 2008:235). This was chosen as suitable design for this study because the researcher needed complete understanding of the experiences of nurses, how they coped and the factors to which the experience is related. The research methodology will be discussed in detail in Chapter 3.

### **1.10.1 Study setting**

The setting refers to the physical location and a condition in which the data collection takes place in the study (Polit & Beck 2008:510). It is an environment where nurses experienced incidents of in-patient suicide. For this study the setting was an urban hospital situated in Gauteng Province, South Africa. This hospital is a district general hospital.

### **1.10.2 Population and sampling**

Population is the entire aggregation of individuals in whom a researcher is interested in. Accessible population is the aggregate of individuals that conform to designated criteria and are accessible as participants for a study (Polit & Beck 2008:337-338; Burns & Grove 2009:42).

The accessible population of this study was nurses licensed to practice by the SANC, who were working at the selected general hospital. Purposive sampling which is a kind of non-probability sampling was used to select a sample of these nurses. The researcher purposively selected nurses that had an experience of caring for patients who attempted or committed suicide successfully whilst admitted in hospital.

This study included nurses who resuscitated patients in casualty department, and those that cared for the patients in the general units prior to the incidents. Data saturation principle determined the size of the sample. However, a total of ten participants were recruited for data collection.

### **1.10.3 Data collection**

Data collection is the precise, systematic gathering of information relevant to research purpose or specific objectives and questions of a study (Burns & Grove 2009:43). In this study an unstructured in-depth individual interview was conducted with nurses who met the inclusion criteria for this study. Unstructured interview is an interview in which the researcher asks participants questions without having a predetermined plan regarding the content or flow of information to be gathered (Polit & Beck 2008:768). The researcher conducted individual interviews at mutually acceptable venues and times with the participants. Data was gathered specifically for the purpose of the research and used to answer the research question and to attain the objectives of this study. No existing data was used.

#### **1.10.4 Ethical considerations**

Ethical clearance and permission to conduct the study were sought from the Department of Health Studies Higher Degrees Committee and Gauteng Department of Health to approach the selected general hospital respectively. Copies of the research proposal and ethical clearance letter from the Higher Degrees Committee of the Department of Health Studies, UNISA were attached (see Annexure A) and sent along to request permission from the Gauteng Department of Health. At the hospital, permission was sought from the nursing service manager and operational managers to interview the nurses (see Annexure B).

The participants were informed about and requested to voluntarily participate in the study. They were also informed that they are free to decline to take part in the study and they may withdraw at any point in the research process. An explanation was given that there would be no negative consequences should they wish not to participate. The rights of the participants were protected through respect, justice and beneficence (Burns & Grove 2009:74).

Informed consent was obtained from participants, following provision of adequate information regarding the research purpose (see Annexure D).

The principle of privacy was adhered to; ensuring confidentiality and anonymity of the participants, in that the findings would be reported without identity of the participants (Streubert Speziale & Carpenter 2007:63-66).

Non-maleficence was ensured by ensuring sensitivity to avoid psychological harm during the study (Polit & Beck 2008:170). Information was given that the study might provoke emotions that could lead to psychological disturbances. Should such psychological disturbances be identified participants would be referred to Employee Wellness Programme for management (Struwig & Stead 2007:67).

Justice was maintained by treating participants with respect; and those who withdrew from the study were still allowed to exercise their right without prejudice (Polit & Beck 2008:174).

The risk that was anticipated to be posed by this study was emotional or psychological disturbance and this risk could be a high risk depending on the participant's ability to deal with emotional strain. When such adverse events occurred the following would be done:

- The interview would be stopped.
- The participant referred to a counsellor (social worker or employee assistance coordinator).
- If the participant is still willing to continue with the study, an alternative date would be set for the interview.

## **1.11 TRUSTWORTHINESS OF THE STUDY**

This study adhered to the four criteria for developing trustworthiness of qualitative inquiry and these include credibility, dependability, confirmability and transferability (Polit & Beck 2008:539).

### **1.11.1 Credibility**

Credibility refers to the extent to which those who read a research report can believe and accept the research findings to be true (Polit & Beck 2008:539). According to Polit and Beck (2008:539), prolonged engagement is essential for building trust and a rapport with the participants, which in turn makes it more likely that useful, accurate and rich information, will be obtained.

In this study the researcher spent time with the participants to obtain a detailed account of their experiences. Interviews were conducted by the researcher in English only. No translation was done and participants understood the language. Credibility was achieved by gathering information from those nurses that have experience of caring for a patient who attempted or successfully committed suicide whilst admitted in hospital. The nurses were asked a grand tour question and the responses were audio recorded and later transcribed verbatim. The verbatim reports were filed and can be used as resource documents but confidentiality will be taken into consideration.

### **1.11.2 Dependability**

Dependability of qualitative data refers to the stability of data over time and over various conditions (Polit & Beck 2008:539). The transcribed interviews and data analysis process were evaluated by an independent reviewer, namely the supervisor. The researcher and supervisor ensured that the empirical phase of the study was conducted in accordance with the focus and boundaries set by the problem statement.

### **1.11.3 Confirmability**

In this study, the researcher involved a purposively selected sample of nurses and conducted in-depth interviews with them. The topic was covered in depth and breadth to ensure that the data obtained supports the provision of thick descriptions.

### **1.11.4 Transferability**

Transferability was achieved by writing comprehensive description of the findings. Comprehensive description will therefore determine the possibility of transferability of findings as this becomes a challenge because people experience incidents in different ways which can be difficult to conclude that the study will be transferable to other settings or groups.

## **1.12 STRUCTURE OF DISSERTATION**

The structure of the dissertation is as follows:

Chapter 1: Overview of the study

Chapter 2: Literature review

Chapter 3: Research design and methods

Chapter 4: Analysis, presentation and description of the research findings

Chapter 5: Conclusion and recommendations

### **1.13 CONCLUSION**

This chapter presented the introduction, background to the study, research problem, purpose and significance of the study, definition of key concepts, and introduction to the research design and methods.

In the next chapter, the literature review will be presented.

## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1 INTRODUCTION**

This chapter presents a literature review on attempted suicide and suicide. Literature review is a critical summary of research on the topic of interest, often prepared to a research problem in context. The purpose of literature review is to expand the researcher's understanding of the phenomenon from multiple perspectives. Thorough literature review helps the researcher to determine how best to make a contribution to the existing base of evidence (Polit & Beck 2008:105-106).

Literature review was done to search the available body of knowledge and to investigate how other researchers discuss attempted suicide and successful in-patient suicide. Reviewing previous studies helped the researcher to ensure that one does not merely duplicate a previous study, and to find out what were the most widely accepted empirical findings in the field (Mouton 2008:87). Several sources were read including medical and nursing journals as well as books that discuss attempted suicide and in-patient suicide. Sources were obtained from the library and the internet.

The researcher acknowledges that there are different opinions with respect to literature review in qualitative study. Some are of the opinion that it must not be done prior to data analysis as it will channel the researcher thus causing bias and others indicate that it can be done prior to data analysis. However, literature review was done to orientate the reader on the context of the phenomenon. Literature review in this study focuses on suicide and both medical and psychological management.

#### **2.2 SUICIDE**

According to Kneisl and Trigoboff (2013:523), suicide is classified as a self-destructive behaviour whereby an individual uses maladaptive measures to restore inner equilibrium when overwhelmed or unable to cope with stressful life events.

Suicide is a fatal act that represents the person's wish to die. It ranges between thinking about suicide and acting it out. Some persons have ideas about suicide that they will never act on, some plan for days, weeks, or even years before acting. Suicide is known for a devastating legacy that it leaves for those who have survived a loved one's suicide, as well as the ramifications for clinicians who cared for the descendants (Sadock & Sadock 2007:897).

### **2.2.1 Epidemiology of suicide**

Globally, suicide rates have increased by 60% in the last few decades and the WHO estimates a worldwide yearly suicide mortality rate of almost one million people which is projected to increase to 1,5 million by 2020. Suicide in the world amount 1,4% of the total mortality and 15% of the injury mortality figures. The global suicide rate is estimated at 11.6% per 100.000 inhabitants. Suicide mortality has moved from Western Europe to Eastern Europe and now seems to be shifting to Asia, while China and India are the biggest contributors to the absolute number of suicides in the world (Takashi, Chida, Nakamura, Yagi, Koeda, Takusari, Otsuka & Sakai 2011:436).

According to the WHO's (2002) global report on violence and health, approximately 30,000 deaths are attributed to suicide each year in the USA. Although significant shifts were seen in the suicide death rates for certain subpopulation during the last century, the rate has remained fairly constant, averaging about 12.5 per 100,000 through the 20<sup>th</sup> century and into the 21<sup>st</sup>. Whereas the overall suicide rate remained relatively stable, however, the rate for those 15-24 years of age has increased two-three fold. Suicide is currently ranked the 8<sup>th</sup> overall cause of death in the USA, after heart disease, cancer, cerebrovascular disease, chronic obstructive pulmonary disease, accidents, pneumonia and influenza, and diabetes mellitus (Neville 2013:35).

In the USA, more than 500,000 patients are treated in hospital emergency rooms for attempted suicide each year, and more than 30.000 people succeed in committing suicide. Suicide is currently the 8<sup>th</sup> leading cause of death for the general American population, and 3<sup>rd</sup> leading cause of death among teenagers. Countries in the European Union seem to be below the world averages of 15.7 per 100,000. Ireland has an

average of 12.9 per 100,000 of the population (WHO 2002). South African suicide statistics at 19 per 100,000 of the population seem to be higher in comparison to industrial nations (Du Toit, Kruger, Swiegers, Van der Merwe, Callitz, Philane & Joubert 2008:20).

The in-patient suicide rate in the USA, China, New Zealand, Austria and UK ranges from 100-400 per 100,000 in-patient psychiatric admissions. Three to 28% of in-patient suicides occur during the first week of hospitalisation while 17%-71% occur within the first month (Combs & Romm 2007:4)

In a study conducted by Meehan, Kapur and Hunt (2006:132) in England and Wales all deaths ruled out suicide or undetermined cause. Research findings showed that 236 patients committed suicide while in in-patient units. From the 236 participants, those that committed suicide whilst on one-one observations were 17 and 139 patients died while on intermittent observation. About 74 patients had absconded while on either one-on-one or intermittent observation. The authors did not describe how the patients under observations were able to commit suicide in the ward or were able to abscond (Jeffrey & Janosky 2009:18). Based on the findings by Meehan et al (2006:132), the researcher noticed that in-patient suicide can be successfully committed even if the patient is on observation management.

A study conducted by Shah and Ganesavaran (1997:295) in Australia, showed that about one third of suicide occurred during periods of approved leave. A similar number occurred after absconding from the hospital. In the same study increased duration of admission and unstable suicidal ideation were cited as the most common factors of in-patient suicide.

The Violence and Injury Mortality Survey of 1999, conducted in five South African provinces, found that suicide accounted for about 8% of all deaths, of which 79% were males. The results of the mentioned survey show that more males than females commit suicide in South Africa. Prevalence of non-fatal suicidal behaviour in South Africa females has higher rates of suicidal ideation and non-fatal suicidal behaviour than males. However non-fatal suicide attempts by males may be underreported because of the stigma associated with such behaviour (Du Toit et al 2008:21).

Suicide among hospitalised medically ill patients is a rare event however when it occurs it poses profound challenges for patients and their families, nurses and hospital administrators. Suicide in medical settings have a substantial effect on the hospital environment especially for nurses that lack specific training on assessment and management of suicide (Ballard, Pao, Henderson, Bostwick, Donald & Rosenstein 2008:474).

Ballard et al (2008:3) indicated that other factors associated with patients' hospitalised medical illnesses include substance abuse, unemployment and other financial stressors, feelings of hopelessness and social isolation.

It is of utmost importance to avoid generalising suicide from culture to culture or group to group because though it can be concluded that suicide rates are generally high amongst adults in many cultures, one cannot say that suicide rates are higher in either urban or rural regions. For instance, in contrast to South Africa where the suicide rate is high in urban areas, in Japan suicide is more common in rural areas (Popenoe, Cunningham & Boulton 2008:8).

In a study exploring the effects of patient suicide on nursing staff, Midence, Gregory and Sanley (1996:115) identified nurses' reactions to patient suicide. Nurses' reactions include sadness, frustration, shock, guilt and depression. The results of the study revealed that the nurses had experienced at least two incidents of suicide or suicide attempt in an acute unit. Bohan and Doyle (2008:2) indicate that the degree of severity of suicide attempts was identified by participants who noted suicidal ideation and low potential of self-harm through to high potential of suicide attempts and completed suicide.

### **2.2.2 A profile of suicide in South Africa**

A 2002 report titled "A profile of suicide in South Africa: 1999" shows the incidence of suicide by province, race and gender, by age and province, by means and finally by place and time. This is important data because it can be used as the basis for managing the initial- home based suicide crisis, for community-based mental health promotion

projects, and suicide prevention projects. Suicide that took place at home accounted for 7, 7% of all non-natural deaths in South Africa. Within this percentage, the rates for each province are, in order from highest to lowest: Northern Cape (13.4%), Gauteng (10.8%), Eastern Cape (9.9%), KwaZulu-Natal (5.9%) and Western Cape (5.0%).

The two most common causes of suicide were by firearm and hanging, firearm most used by police officers. South African suicide rates range from 11.5% per 100,000 to as high as 25 per 100,000 of population. About 11% of all non-natural deaths are suicide related. On average 9.5% of all non-natural deaths in young people are due to suicide which is almost as high as the adult suicide rates (Takashi et al 2011:436).

A study conducted by Townsend (2003:77) investigating the phenomenon of murder-suicide in KwaZulu-Natal, revealed that during the year 2000 there were 1,111 homicides reported in to the police, of which 47% were murder-suicide deaths. In 2001 a total of 1,054 homicides were reported in the same police, representing 44.5% of all unnatural deaths. It is not clear on the study whether suicide was committed at home or in hospital.

The South African Stress and Health (SASH) (2009) study revealed that lifetime prevalence of any disorder was 30.3%. An estimate of 11.2% of the respondents had two or more lifetime disorders and 3,5% had three or more lifetime disorders. Most prevalent class was anxiety disorders, followed by substance use disorders and mood disorders. Alcohol abuse and major depressive disorders were also amongst the lifetime disorders indicated (Herman, Stein, Seedat, Heering, Moolman & Williams 2009:339).

### **2.2.3 Incidence and prevalence of suicide**

Suicide is one of the commonest causes of non-disease related death and it is a major public health problem worldwide. Both fatal and non-fatal suicide behaviours constitute a considerable problem in terms of individual suffering as well as the burden on health care and costs to society. Attempted suicide is 8 to 10 times higher than the number of successful suicides (WHO 2002).

A study conducted by Cassels, Peterson and Morris (2005:58) in Ireland on incidence and repetition of deliberate self-harm, showed that between 2003-2009 the registry recorded 75,119 deliberate self-harm presentations to the hospital in Ireland involving a total of 48,206 individuals. The annual total, male and female rate of persons presenting with self harm were 95% per 100,000. The total incident rate fell by 2-6% annually from 2003-2006 then increased by 2-6% per year per 100,000 in 2009. The most notable annual changes were two successive 10% increase in male rate. Overall, the female rate was 29% higher than male rate though this sex difference reduced in recent years from 38% in 2005 to just 13% in 2009. Gender and age showed substantial variation in incidence of hospital-treated deliberate self harm for both women and men with a peak in 15-19 year old women almost twice equivalent male rate. In males the highest rate was observed in 20-24 year age group.

#### **2.2.4 Suicide attempts**

Suicide attempts constitute a serious problem for public healthcare services. Suicidal behaviour not only includes suicides, but also those suicide attempts which do not result in patient's deaths. Mental phenomena such as suicidal impulses or unconsummated ideations can also be included, as well as wide range of behaviours which are pernicious to the patient's health without a previous explicit declaration of a suicidal intention (Alberdi-Sudupe et al 2011:1).

A variety of factors are associated with an increased risk of suicide and attempted suicide, including psychiatric disorders, feelings of hopelessness and impulsivity, history of previous suicide attempt, age and race, marital status occupation, co-morbidity, adverse childhood experiences, family history and accessibility to weapons. Some individuals who attempt to commit suicide are taken to emergency departments in general hospitals, while others remain in their family or social environment after the attempt, with no specific health care (Alberdi-Sudupe et al 2011:1).

#### **2.2.5 In-patient suicide in a general hospital**

In-patient suicide is the second most common sentinel event reported to the Joint Commission (2007), which has identified suicide prevention as a National Patient Safety

Goal. Suicide prevention is influenced by health care professionals' ability to accurately assess a patient's suicide risk. Evidence suggests that lack of knowledge and unfavourable attitudes towards suicide negatively impact health care delivery and patient safety (Neville 2013:35).

In-patient suicide is considered a rare event, however it is estimated that the suicide rate is three times higher than that of the general population. Physical and emotional distress experienced by patients during hospitalisation increases the risk of in-patient suicide. Poorly managed pain, disease exacerbation and treatment failure are identified along with suicidal thoughts among adults with cancer (Neville 2013:36).

Valente and Saunders (2004:644) conducted a study in the USA, Canada and Puerto Rico regarding barriers of suicide risk assessment among members of the Oncology Nursing and the findings revealed that nearly 50% of nurses miscalculated suicide risks, and barriers to management of suicidal patients were noted. Barriers included deficits in knowledge, skill and referrals, patient teaching advocacy and consultation. The nurses reported feeling uncomfortable, not knowing how to respond to a suicidal patient and feared responding inappropriately. Perceptions of increased professional responsibility, personal and religious values were also mentioned (Neville 2013:38).

In a study conducted by Botega, Reginato, Da Silva, Da Silva, Rapeli, Mauro and Stefanello (2005:316) in South America, investigating nursing personnel employed in general hospital to determine their attitudes towards suicide risk, the findings revealed that the nurses described themselves as prepared to care for suicidal at risk patients, and perceived themselves as capable of detecting suicidal tendencies in patients. The results indicated that the nurses disagreed with a person's right to commit suicide, with religion influencing this attitude (Neville 2013:39).

Patient safety has been increasingly recognised as an important concern in hospital settings, and in-patient suicide is the second common sentinel event according to the Joint Commission on Accreditation of Health Care organisations (Joint Commission 2008). In-patient suicide rates vary substantially and depend on the type of hospital estimation methods. Its range is 5-15 and 100-400 per 100,000 admissions in general

and psychiatric hospitals respectively and is estimated to be responsible for 1-5% of total suicides (Cheng et al 2009:110).

Cheng et al (2009:111) indicated that though rare, in-patient suicides often indicate great patient distress and have devastating effects on survivors and on staff morale. Compared with many studies that concentrate on patients in a mental setting, patients who commit suicide or attempt suicide in a general hospital receive considerably less attention in medical literature. Little is known about profiles or characteristics of in-patients who attempt suicide and the relationships of patients with attempted suicide and those who completed suicide in hospital. Common characteristics such as male predominance, more violent methods, association with depressive disorders, absence without leave, history of previous suicide attempts, emotional difficulties, poor relationships with hospital staff and family contribute to rapid occurrence of suicides in psychiatric or general hospitals (Cheng et al 2009:110).

Distinctive features of suicidal patients has been described in independent studies such as older age or having physical conditions (such as pulmonary disease or terminal illness) in general hospital settings and psychopathology of mental illness in psychiatric hospital settings. However, only one hospital has examined patients admitted to medico-surgical or psychiatric wards consensually and compared characteristics of in-patient suicide across different settings. Patients with physical illness have two to three times higher risk of completed suicide than those without but many suicide victims with physical illness have also suffered from concurrent mental disorders (Cheng et al 2009:111).

There are few studies in which epidemiological data have been collected on in-patient suicides. In a study conducted in Canada on successful in-patient suicide, five patients successfully committed suicide whilst in the ward. A case control study done in Hong Kong by Dong, Ho and Kan (2005:94) showed that 93 in-patient suicides, 75 patients were on unauthorised leave and 12 patients were on authorised leave at the time of suicide leaving only six patients in the ward at the time of suicide (Janofsky 2009:19).

In-patient suicide rate in the USA, China, New Zealand, Australia and Austria ranges from 100-400 per 100,000 in-patient psychiatric admissions. Approximately 3% of in-

patient suicides occur during the first week of hospitalisation while 17% occur within the first month of hospitalisation (Combs & Romm 2011:3).

## **2.2.6 Care of the suicidal patient**

A highly suicidal patient cannot be cared for at home, and should be hospitalised. The decision about whether hospitalisation should occur is dependent on the patient's suicide risk, the level of supervision available at home, the patient and the family's wishes. However patient's safety should be the first consideration.

Health care professionals believe that an appropriate goal for psychiatric in-patient is to maximise the chances of survival rather than to guarantee survival. Good nursing care can often make the difference between life and death for suicidal patients. It is important that all nursing actions can be described as therapeutic interpersonal skills which are regarded by mental health nurses as the cornerstone of nurse-patient relationship (Uys & Middleton 2010:396).

### **2.2.6.1 Nursing self-awareness**

Nurses caring for suicidal patients should be aware of their reactions, monitor their reactions to a potential life threatening situation because nurses' reactions may interfere with their ability to accurately assess and intervene. Suicidal patients present with unique challenges and they require all available resources therefore nurses should be able to ask the right questions and make right decisions as well as manage their own fears and anxieties because helping a client who deliberately wants to harm or kill himself is a complicated process. Nurses should build a therapeutic trusting relationship with the patient by showing compassion to encourage the patients to recognise that nurses are not allies. Similarly, nurses should ensure enough detachment to avoid being overwhelmed by the patient's pain. Feelings such as patient's anger, fear, anxiety, irritability or hostility need to be tolerated, worked through and evaluated. Nurses must be competent not only to assess but also to intervene effectively with clients hence they need to be trained on management of mental disorders. Nurses' attitudes when working with self-destructive patients may include feelings such as frustration and anger amongst them. It is therefore important for nurses to assess

personal feelings, experiences, conflicts and memories that may impede or facilitates nurses' effectiveness on management of suicidal patients (Kneisl & Trigoboff 2013:515).

### **2.2.6.2 Assessment for suicide**

Patient assessment includes a self-awareness of the nurse, identification of clues or cries for help and accurate lethality assessment. With regards to clues or cries for help, people's intent on suicide always gives either verbal or non-verbal clues or cry for help of their plans or ideas. Some individuals who commit suicide may signal their need for help by making social contact with someone in the health care system, unfortunately, the cry for help is not always clear until after the incident. Nurses should be alert of clear and unclear communications from the patient about suicide. Nurses are encouraged to always perform patient assessment for suicide whenever they suspect suicidal thought or intention (Kneisl & Trigoboff 2013:16).

Lethality assessment is an attempt to predict the likelihood of suicide. Assessment of risk factors is essential in order to determine the client's need for hospitalisation or the extent of watchful precautions to take when patients are hospitalised. Lethality assessment requires direct communication with the client about his/her intent. Another component of suicide is to assess the proposed method of committing suicide. There are gender differences in methods of committing suicide. Women tend to use less violent methods such as drug over dose whilst men tend to use more violent methods such as firearms and hanging (Kneisl & Trigoboff 2013:516).

### **2.2.6.3 Planning and implementation for suicidal patients**

According to Uys and Middleton (2010:398), nursing interventions strive for prevention of suicide as an ideal outcome however ideal circumstances are not available and therefore ideal outcomes do not always results. The priority task is to work with the client to stop thinking about suicide, long enough to enable the client to consider alternatives to suicide.

Harm should be reduced by limiting the opportunities for suicide by removing potentially harmful items such as sharp instruments, cleaning agents, medication and electrical

cords. The environment should be regularly monitored. It is important that the cubicle in which the patient is admitted is accessible to nursing staff for observation for example a cubicle that is near nurses' station is recommended.

Articles brought by relatives should be observed and an explanation should be given to relatives that articles that pose a threat to the patient will not be allowed for the purpose of ensuring patient safety. In cases of extreme risk of suicide, immobilise the patient through sedation. Sedation reduces patient's level of consciousness; patient sleeps a lot. Ward policies on prevention of suicide should be developed in order to provide guidance to nursing personnel caring for suicidal patients. Policies should provide the following guidelines:

- Maintain a 24-hour observation period recording and specifically the patient's behaviour, with particular attention to changes in mood, a raised energy level and a change in the ability to concentrate.
- Identify a time when the patient may be more motivated to commit suicide.
- Identify and plan times of low staff/patient ratio such as staff changes and night duty. At such times there is a need for special awareness of the patient's behavioural patterns.
- Initiate positive intervention to decrease risk of suicide.
- Negotiate a no-suicide contract with the patient to give staff the opportunity to assist the patient in a crisis (Uys & Middleton 2010:399).

### **2.2.7 Management of suicide**

Most suicides amongst psychiatric patients are often preventable, because evidence indicates that inadequate assessment or treatment is often associated with suicide. Evaluation of suicide potential involves a complete psychiatric history, a thorough examination of the patient's mental state, and an inquiry about depressive symptoms, suicidal thoughts, intent, plans and attempts. A lack of future plans, giving away personal belongings, making a will and having recently experienced a loss all imply risk of suicide. The decision to hospitalise a patient depends on diagnosis, depression severity and suicidal ideation, the patient's and family's coping abilities, the patient's

living situation, availability of social support and absence or presence of risk factors for suicide (Sadock & Sadock 2007:903).

On admission of a suicidal patient, useful measures for treatment of depressed suicidal patients include searching patients and their belongings on arrival in the ward for objects that could be used for suicide; and the search should be repeated at times of exacerbation of suicidal ideation. However constant observation by special nurses (who may be nurses allocated specifically to care for the suicidal patient alone), seclusion and restraints cannot prevent suicide when the patient has decided on committing suicide and find an opportunity to do so. Medications that have antipsychotic and antidepressant effects must be given if the patient is presenting with signs and symptoms of both psychosis and depression. In hospital patients receive individual therapy whereby they have counselling sessions with trained psychiatrist nurses and psychologists. Group therapy is also used as a treatment method where patients discuss about suicide and the alternatives they use to avoid suicide. Supportive therapy by a therapist shows concern and may alleviate some of patient's intense suffering. Patients should be dissuaded from making major life decisions when they are suicidally depressed because they might take decision that are irreversible. Special observations should be done on depressed patients who suddenly appear to be at peace with themselves; because such behaviour is an indication that they reached a decision to commit suicide. A survey by Kaplan and Sadock (2007) in Sadock and Sadock (2007:905) indicated that about 1% of all suicides were committed by patients who were treated in general medical-surgical or psychiatric hospitals.

### **2.2.8 Care of the suicide survivor**

Suicide survivors refer to those who have lost a loved one to suicide, not to someone who has attempted suicide but lived. Survivors feel that the loved one intentionally and wilfully took his or her life and that only if the survivor had done something differently, the decedent would still be here. Because the decedent cannot tell them otherwise, survivors are at the mercy of their often merciless consciences (Kneisl & Trigoboff 2013:524).

For children, loss of a parent to suicide feels like a shameful abandonment for which the child may blame himself or herself. For parents of children who have killed themselves, their grief is compounded not only by having lost a part of themselves, but also by having failed in what they perceive as their responsibility for the total feelings of their children (Sadock & Sadock 2007:906).

When death occurs by suicide, family members often experience bewilderment, sorrow and shock. Feelings of guilt, anger and depression set in. It is of utmost importance that individual members of the family undergo counselling to help them cope with the trauma of such experience; however, such consultations have financial implications on the family. Sometimes the family is subjected to trauma of judicial inquiry bringing further stress to the life of those concerned. Due to stigmatisation of suicide the family may experience varying degrees of withdrawal from extra-familial interaction, even close friends may find difficult to maintain personal relationships because they do not know how to deal with the situation. Conflict may develop amongst family members because they blame themselves and eventually resort to blaming each other for the suicide causing some families to become temporarily or permanently disorganised (Bezuidenhout 2008:124).

The immediate care offered may vary from supportive counselling to crisis intervention. The survivors may then be referred to an agency for counselling. The following areas may be explored:

- Acceptance of suicide.
- Sharing feelings about the suicide and feelings preceding suicide.
- Managing questions posed by friends and other community members about suicide.
- Coping with grief (Uys & Middleton 2010:400).

### **2.2.9 Suicide in medically ill patients**

The medical and nursing literature contains very limited information regarding suicide related to medical illness. A study conducted by Ballard et al (2008:480) revealed that in-patients on medical floors tend to commit suicide by jumping from heights whilst in-

patients from psychiatric units hang themselves.

Brain pathology can trigger depression, suicidal ideation and lack of restraint. Reduced serotonergic input to the orbital pre-frontal; cortex (part of brain involved in behavioural inhibition and decision making) may result in aggressiveness/impulsivity. In such cases there is a decrease in pre-synaptic binding sites in the pre-frontal cortex and serotonergic hypofunction which may be associated with more lethal methods of choice in suicidal behaviour (Schlebusch 2005:185,186).

Schlebusch (2005:189) in a study on suicidal behaviour in medically ill patients indicated that there can be a relationship between physical disease and suicidal behaviour. For example in some instances a link has been shown between indirect self-destructive behaviour resulting from analgesic nephropathy (end-stage renal disease as a result of analgesics abuse), and suicidal behaviour and potentially life-threatening diseases such as cancer and HIV/AIDS.

Cancer patients commit suicide most frequently in the advanced stages of the disease. Patients with advanced illness are at high risk, perhaps because they are most likely to have such cancer complications as pain, depression, delirium, and deficit symptoms that increase vulnerability to suicide (Schlebusch & Burrow 2009:105).

The study further revealed that there is growing evidence of long term sequelae in childhood cancer that can contribute to suicide risk factors in adulthood due to traumatic experiences of children with cancer as a result of hospitalisation, oncology treatment and altered social contact (Schlebusch 2005:189).

#### **2.2.10 Impact of in-patient suicide on the nurses**

Psychiatric disorders are identified as among the strongest risk factors for suicide. Psychiatric in-patients constitute a high risk group for suicide attempts. Nurses working in psychiatric hospitals and psychiatric wards are more prone to encounter suicidal ideation in patients and attempted or completed suicide than nurses in other departments (Takahashiet al 2011: 1)

A study conducted by Takahashi et al (2011:3) in Japan indicated that more than half of nurses who encountered suicide by patients stated that they had at least some contact with them. The nurses indicated a desire for mental health care programmes for health care workers who have experienced a shocking event on the ward. This indicates that nurses are aware of the need for staff-oriented mental health care services. This study further revealed that the nurses had encountered patient suicide, a very low rate of nurses reported attending in-hospital seminars on suicide prevention or mental health care for nurses.

Reactions of staff members to suicide vary according to the roles they perform to patients. Professional nurses perform patient assessments, counselling and giving medication, whilst nursing assistants monitor patients' vital signs. Based on time spent with patient by different categories of nursing personnel, professional nurses might be more affected by patient suicide than nursing assistants (Kneisl & Trigoboff 2013:525).

Valente and Saunders (2002:6) explored clinicians' response following in-patient suicide. The findings revealed that direct traumatic experience of a patient suicide may lead to clinicians' professional growth or in contrary may leave a heavy, often long lasting psychological burden. Feelings of fear and harsh judgements from colleagues emerged. Long-term effects included loss of confidence in professional competence and fear of malpractice lawsuits.

Sadness, anger, denial and shame are common reactions presented by nurses when a patient commits suicide whilst admitted in hospital. Staff members may lack confidence and be unable to function effectively. Other reactions among nurses ranged from refusing to admit suicidal patients to their units to recognising what the particular problems were and how they might manage them better in future. Counselling and implementation of critical incident stress debriefing (CISD) by specialised therapist or crisis management social workers is very important for nurses in order to give them an opportunity to discuss their thoughts and feelings about the traumatic event. CISD is a group therapy whereby nurses who experienced a traumatic event are gathered together to discuss their feelings about the event. Staff members with little medical training or experience suffer more than those who have previously encountered illness

and death therefore these staff members need extra attention (Kneisl & Trigoboff 2013:525).

Hummelvoll and Severinsson (2001:159) reported that mental health professionals cited that an unpredictable and demanding working environment, responsibilities, occasional lack of clinical supervision and inadequate and dangerous surroundings contributed to anxiety and eventually burnout. According to Spitzer and Burke (1993:147), multiple symptoms experienced by staff following in-patient suicide include cognitive impairments with inability to make decisions. Staff also reported physical problems such as fatigue and headache following the death of a patient in their care. Joyce and Wallbridge (2003:19) considered effects of in-patient suicide on nurses and they found that nurses became angry, tense and critical of colleagues' management of the incident. It was evident that nurses who adhered to spiritual beliefs appeared to cope better with in-patient suicide. Some nurses found post-event debriefing helpful while others felt overwhelmed by a meeting and wanted to be left alone (Combs & Romm 2007:10).

In avoidance, one's response to trauma is to try to avoid what happened. The person tries not to think about the experience and avoids places and things associated with the event. The person refuses to talk about aspects that were particularly awful, and may use substances such as alcohol or medicines to block out feelings and memories. They avoid trauma because to think about the event is like "going back and experiencing it again" which is frightening and painful (Uys & Middleton 2010:657).

Re-experiencing occurs when one experiences nightmares and/or flashbacks, or thinks about the event even when he or she is trying not to. It is as if the memory keeps resurfacing to haunt the person. The tendency both to avoid the trauma and, at times to re-experience it is normal. Most trauma survivors swing between these two responses for some time after the traumatic event (Uys & Middleton 2010:657).

### **2.3 POST-TRAUMATIC STRESS DISORDER**

Post-traumatic stress disorder (PTSD) is a condition marked by development of symptoms after exposure to traumatic life events. The person reacts with fear and helplessness, persistently relives the event and tries to avoid being reminded of it.

Individuals who are exposed to traumatic events experience some of the symptoms of PTSD in the days or weeks following exposure. Traumatic events such as finding a deceased patient hanging on a curtain rail having committed suicide in the unit bring sadness, guilt and hopelessness to nurses that took care of the patient prior the suicide event. Risk factors of PTSD include female gender and the nature of the trauma (Baumann 2008:410).

Common reactions experienced by care givers are guilt anger, self-blame, sadness, fear and feelings of professional failure. All or some of the reactions may be projected onto patients or colleagues. A support group meeting for staff should be held when staff availability allows. Staff will then have the opportunity of discussing their personal feelings about suicide and exploring these. This exercise can create their group cohesiveness and a support system. It can also provide an opportunity for unit policies to be reviewed and updated, creating a learning experience from suicide (Uys & Middleton 2010:400).

## **2.4 CONCLUSION**

In this chapter literature review was presented, including the profile of suicide in South Africa, care of suicidal patient, treatment and the psychological support of caregivers have been explained. The next chapter presents the research methodology.

## **CHAPTER 3**

### **RESEARCH METHODOLOGY**

#### **3.1 INTRODUCTION**

This chapter will outline research design and methods that were used to explore the experiences of nurses caring for patients who attempted suicide or successfully committed suicide whilst admitted in a general hospital.

#### **3.2 RESEARCH PURPOSE**

The purpose of the study was to design support guidelines for the nurses who care for patients who attempt or successfully commit suicide whilst admitted in a general hospital.

#### **3.3 RESEARCH OBJECTIVES**

The objectives of this study were to

- explore the experiences of nurses regarding incidents of patients committing suicide in hospital
- describe the effects of suicide events on nurses caring for patients who attempted or successfully committed suicide whilst admitted in hospital
- design support guidelines for the nurses who care for patients who commit suicide whilst admitted in hospital

#### **3.4 RESEARCH DESIGN**

Polit and Beck (2008:66) define research design as the overall plan for obtaining answers to the questions being studied during the research process. This study followed a generic qualitative exploratory and descriptive research design. Qualitative

research design follows a naturalistic paradigm that assumes that knowledge is maximised when the distance between the enquirer and the participants in the study are minimised. Voices and interpretations of those under study are crucial to understanding the phenomenon of interest and subjective interactions are the primary ways to access them. Qualitative research offers an opportunity to focus on finding answers to questions centred on social experience, how it is created and how it gives meaning to human life. Naturalistic methods of enquiry attempt to deal with human complexity by exploring it directly. The emphasis is on the complexity of human beings, their ability to shape and create their own experiences and the idea that the truth is a composite of realities. Human beings are used directly as the instrument through which information is gathered (Polit & Beck 2008:15, 17).

Qualitative research is a systematic, subjective approach used to describe life experiences and give them significance. It is a way to gain insights through discovering meanings. Insights are obtained not through establishing causality but through improving comprehension of the whole. Qualitative research design explores the depth, richness and complexity of inherent phenomena (Burns & Grove 2009:51).

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The focus of qualitative research is usually broad and the intent is to give meaning to the whole. The qualitative researcher plays an active role in the study. This research approach is subjective, but the approach assumes that subjectivity is essential for understanding of human experiences (Burns & Grove 2009:23). The goal of a qualitative research design is to develop a rich understanding of a phenomenon as it exists in the real world and as it is constructed by individuals in the context of that world.

Qualitative research places heavy emphasis on understanding human experience as it is lived through careful collection and analysis of qualitative material that are narrative and subjective (Polit & Beck 2008:219). Qualitative research seeks to arrive at

an understanding of a particular phenomenon from the perspective of those experiencing the phenomenon (Streubert Speziale & Carpenter 2007:23).

In this study the researcher strived to understand the individual personal experiences of nurses regarding attempted suicide or successful in-patient suicide.

Qualitative research methods are especially useful for exploring the full nature of a little understood phenomenon (Polit & Beck 2008:20-21). The researcher strives to expose individual personal experiences of nurses regarding attempted suicide and successful in-patient suicide in a general hospital in Gauteng.

Exploratory research begins with a phenomenon of interest, but rather than simply observing or describing it, exploratory research investigates the full nature of the phenomenon, the manner in which it manifested and the other factors to which it is related. In this context it was in-patient suicide as it is constructed by nurses who cared for the patients.

Descriptive research is a non-experimental research with a purpose of observing, describing and documenting aspects of a situation as it naturally occurs (Polit & Beck 2008:274). Descriptive study designs are crafted to gain more information characteristics within a particular field of study. The purpose is to provide a picture of a situation as it naturally happens (Burns & Grove 2009:237).

### **3.5 RESEARCH METHODS**

Research method is the technique used to structure a study and to gather and analyse information in a systematic fashion (Polit & Beck 2008:765). This study followed descriptive and exploratory research methods. The study was conducted in an urban district hospital in Gauteng Province. According to Polit and Beck (2008:766), setting refers to physical location and conditions in which data collection takes place in a study. The interviews were conducted in an office within the hospital during the off duty time of participants.

### **3.5.1 Population and sampling**

Population is the entire aggregation of individuals in which a researcher is interested in. On the other hand, accessible or source population is the aggregate of individuals that conform to designated criteria and are accessible as participants for a study (Polit & Beck 2008:337-338; Burns & Grove 2009:42).

The accessible population of this study was nurses working in the selected general hospitals, who had an experience of taking care of a patient who attempted to commit or committed suicide successfully whilst admitted in the hospital.

### **3.5.2 Sample and sampling method**

Sample denotes the selected group of people included in the study. Sampling involves selecting a group of people, events, behaviours or other elements with which to conduct a study (Burns & Grove 2009:343). The sample for this study included nurses who had experience of caring for patients who attempted to commit suicide or who have successfully committed suicide in a general hospital in Gauteng.

A non-probability purposive sampling method was used in this study whereby the researcher purposively selected nurses with rich information regarding patients who attempt to commit suicide or successfully commit suicide in a general hospital in Gauteng.

The researcher took into cognisance that there is criticism around the size of the sample for qualitative studies hence the researcher ensured that data was collected until saturation was reached. The researcher planned to interview ten participants but stopped when data saturation was reached.

The participants were selected and included according to specific inclusion criteria. Eligibility or inclusion criteria refer to those characteristics that participants must possess to be part of the target population (Polit & Beck 2008:338). The inclusion criteria for this study were:

- Nurses registered with the South African Nursing Council who had an experience of taking care of patients who attempted to commit suicide or successfully committed suicide in a general hospital in Gauteng at the approved study setting.
- Nurses must have worked in medical wards of the approved study setting during the period 2008-2012.

### **3.5.3 Data collection**

Data collection is the process of getting data from participants through a formal guide developed by the researcher to guide collection of data in a fashioned manner (Polit & Beck 2008:751).

In this study an in-depth unstructured interview was conducted with nurses who had an experience of in-patients who attempted or successfully committed suicide. The interview was conducted by the researcher in the approved institution for conducting the study from July 2013 until October 2013. The interviews were conducted in English, and no translation was done as all the participants understood and could speak English. The researcher asked participants questions without having a predetermined plan regarding the content or flow of information to be gathered.

The participants were interviewed in an office within the institution during their off-duty time in an environment that was free of disturbance. Cell phones were turned off. An audio tape was used for recording the interview; with the consent for recording obtained from the participants.

The participants were asked a grand tour question that they responded to with minimal interruption. The participants were interrupted only when the researcher sought clarity. Data was gathered for the purpose of the research specifically and was used to answer the research question or to attain the objectives of this study. No existing data was used.

The grand tour question was:

“What are your experiences regarding in-patients who attempted or successfully committed suicide in hospital?”

Literature indicates that there are advantages and disadvantages of using interviews for data collection. Burns and Grove (2009:405) highlight the following advantages:

- Interviewing as a flexible technique that can allow the researcher to explore greater depth of meaning than he or she can obtain with other techniques.
- Researchers elicit more information through use of interpersonal skills that encourages participant’s cooperation.
- Response rate to interviews is higher than that of questionnaires.

In this study the advantages were that the researcher was able to

- gain an in-depth meaning of nurses’ experiences regarding in-patients who attempted or successfully committed suicide
- gain more clarity through follow-up questions
- maintain good interpersonal relations with participants that led to openness and transparency
- build trust and gained cooperation from participants.

Disadvantages included the following:

- The interview exceeded the agreed upon time because the participants were willing to give more information about their experiences.
- Some participants became very emotional during an interview to such an extent one interview was postponed.
- Sample was limited to six nurses.

#### **3.5.4 Data collection process**

Audio recorded interviews were transcribed verbatim into a Microsoft Word document. The transcripts were printed and analysed manually. The verbatim

transcripts were dated, labelled with the pseudonyms PARTICIPANTS, which is P1-P6. The participants were given pseudonym according to the sequence of appointments for interviews. For example interview 1 was labelled P1, (meaning it was participant who was the first to be interviewed).

### **3.5.5 Data management**

Burns and Grove (2009:447) indicate that when data collection begins the researcher will have to handle large quantities of data. It is important to have a data management plan to avoid confusion. In this study the researcher coded data after data collection and entered it into the computer. The researcher transcribed interviews using different colours, one colour was used for response to questions related to experience, the other was used for other responses that came out during the interview. Data recorded on a computer was backed up with a flash disk to safeguard it against loss. After each and every interview data was captured in the computer and a hard copy was printed and filed in a folder. Data was stored in a flash disk and it will be retrieved when necessary.

### **3.5.6 Data analysis**

Data analysis involved “breaking up” data into manageable themes, patterns, trends and relationships. The aim of data analysis was to understand various constitutive elements of data through an inspection of the relationship between concepts, constructs and to see whether there are any patterns that can be identified or isolated to establish themes in the data (Mouton 2008:108).

Qualitative data analysis is the process of systematically organising the field notes, interview transcripts and other accumulated materials until the researcher understand them in such a way as to address the research questions and can present that understanding to others (Bailey 2007:137). Qualitative data analysis took place concurrently with data collection; therefore the researcher tried to gather, manage and interpret huge amounts of data simultaneously. The purpose was to organise, provide structure to and elicit meaning from research data to obtain a clear understanding of participant’s experiences (Polit & Beck 2008:507-508).

Data analysis began with listening to the audio-recordings of the participants' verbal descriptions, followed by reading the verbatim transcriptions to come to an overall understanding of each participant's experience (Streubert Speziale & Carpenter 2007:69). In this study, the researcher commenced with the process of data analysis by reading the verbatim transcriptions in preparation for coding the data.

Coding is a means of categorising. A code is a symbol or abbreviation used to classify words or phrases in data. The researcher described the domain of this study through selection of codes (Burns & Grove 2009:509).

Data analysis required that the researcher to dwell or become immersed in the data. As the researcher became immersed in the data, relevant important statements were identified and extracted (Streubert Speziale & Carpenter 2007:96). In this study the researcher assigned colour codes to each text unit and coding occurred in accordance with colour codes.

During data analysis, important concepts were grouped into categories, thus reducing them to a more manageable number. Once the numbers of concepts were decreased, the researcher was able to discover interrelationships between the categories and to develop a limited number of unifying themes (Polit & Beck 2008:510).

In summary the study followed a general qualitative data analysis whereby the following process was followed:

- Participant's verbatim transcripts were read to acquire a sense of the whole.
- The researcher began by searching for broad categories or themes that emerge from collected data.
- The researcher derived these themes from narrative material whereby the researcher went back to narrative material with themes in mind to see if materials really do fit and then refined themes as necessary (Polit & Beck 2008:515).

## **3.6 TRUSTWORTHINESS OF THE STUDY**

Trustworthiness refers to the degree of confidence qualitative researchers have in their data, and was assessed using the criteria of credibility, transferability, dependability, confirmability and authenticity (Polit & Beck 2008:768). Scientific rigor is valued because it is associated with the worth of research outcomes. In qualitative research rigor is associated with openness, relevance, epistemological and methodological congruence, scrupulous adherence to a philosophical perspective, thoroughness in collecting data and consideration of all data in the analysis process, and the researcher's self-understanding (Burns & Grove 2009:54).

### **3.6.1 Credibility**

Credibility refers to the extent to which those who read a research report can believe and accept the research findings to be true. Prolonged engagement is essential for building trust and a rapport with the participants, which in turn makes it more likely that useful, accurate and rich information, will be obtained (Polit & Beck 2008:539). In this study the researcher spent time with the participants to obtain a detailed account of their experiences. Credibility was ensured by gathering information from those nurses that had experience of caring for a patient who attempted or successfully committed suicide whilst admitted in hospital. The nurses were asked a grand tour question and the responses were audio recorded and later transcribed verbatim. The verbatim reports were filed and could be used as resource documents but confidentiality will be taken into consideration. All the interviews were conducted by the researcher self, to ensure consistent follow-up on questions

### **3.6.2 Dependability**

Dependability of qualitative data refers to the stability (reliability) of data over time and over various conditions (Polit & Beck 2008:539). Dependability as a criterion is met once researchers have demonstrated the credibility of the findings (Streubert Speziale & Carpenter 2007:38). The transcribed interviews and data analysis process were evaluated by an independent reviewer, namely the supervisor. The researcher and supervisor ensured that the empirical phase of the study was

conducted in accordance with the focus and boundaries set by the problem statement.

### **3.6.3 Confirmability**

Confirmability refers to objectivity, the potential for congruence between two or more independent people about the data's accuracy, relevance or meaning. The researcher reported on the information provided by participants and the interpretations of that data excluding the researcher's imaginations (Polit & Beck 2008:539). The researcher involved a purposively selected sample and conducted in-depth interviews with them. The topic was covered in depth and breadth to ensure that the data obtained supports the provision of thick descriptions. The researcher bracketed her personal experiences related to the topic by ensuring not to bring out her own thoughts about the topic.

### **3.6.4 Transferability**

Transferability refers to the generalisability of data, that is, the extent to which findings can be transferred to or have applicability in other settings or groups (Polit & Beck 2008:539). The researcher provided thick descriptions to enable someone interested in making transfer to reach a conclusion on whether transfer to other settings or groups is possible. Thick descriptions were attained because information rich participants were included in the sample. Thick description refers to a rich and thorough description of research setting and of observed transactions and processes (Polit & Beck 2008:202).

## **3.7 ETHICAL CONSIDERATIONS**

Polit and Beck (2008:753) describe ethics as a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal and social obligations to the study participants. Ethical clearance and permission to conduct the study was requested from the University of South Africa (UNISA), Department of Health Studies Higher Degrees Committee and Chief Executive Officer (CEO) of the hospital respectively (see Annexures A & B).

A copy of the research proposal and a copy of the ethical clearance letter from the Higher Degrees Committee of the Department of Health Studies, UNISA was attached and sent along to request permission from the Gauteng Department of Health. At the hospital, permission was obtained from the operational managers to interview the nurses (see Annexure C).

The participants were informed about the study and requested to voluntarily participate in the study. Information was provided to the participants that they were free to decline to take part in the study and that they could withdraw at any point in the research process, if they so wished. An explanation was given that there would be no negative consequences should they wish not to participate. Information was given that the study might provoke emotions that could lead to psychological distress. Should such psychological distress be identified participants would be referred to Employee Wellness Programme for management (Struwig & Stead 2007:67). The rights of the participants were protected through beneficence, respect for human dignity and justice (Burns & Grove 2009:189).

### **3.7.1 Beneficence**

Beneficence is a principle that imposes a duty on the researcher to minimise harm and to maximise benefits. Human research should be intended to produce benefits for participants themselves. The researcher had an obligation to avoid, prevent, or minimise harm (*non-maleficence*). The participants were not subjected to unnecessary risks for harm or discomfort (Polit & Beck 2008:170). Confidentiality and anonymity were maintained in that the participants were treated with privacy; ensuring that the information they provided was not given to anyone who would use it against them.

### **3.7.2 Respect for human dignity**

The principle of human dignity encompasses people's right to make informed, voluntary decisions about the study participants, which requires full disclosure. The researcher had fully described the nature of the study; the participant's right to refuse participation,

the researcher's responsibilities and the likely risks and benefits (Polit & Beck 2008:172). Comprehensive information about the study was given to participants so that they could take an informed voluntary decision.

### **3.7.3 Justice**

Justice refers to participant's right to fair treatment and to privacy (Polit & Beck 2008:174). The participants were treated fairly by not coercing them to participate in the study; those that were not interested in participating in the study were not prejudiced. The right to privacy was ensured by conducting interviews in an office at a mutually agreed venue and mutually agreed time where privacy was maintained; the names of the participants were replaced with pseudonyms on documents that were used during interviews.

### **3.7.4 Scientific integrity of the research**

Mouton (2008:240) emphasised that researchers should at all times strive to maintain objectivity in their conduct of scientific research. Research findings should be presented honestly without manipulation of information received from participants. The researcher complied with scientific integrity by acknowledging sources of information to avoid presenting ideas of other authors as own (Polit & Beck 2008:180).

Falsification of the study was avoided by presenting the research findings without manipulating, changing, omitting data or distorting results to ensure honesty. Cognisance around fabrication was taken into consideration. The findings of this study are a true reflection of what was obtained during research process (Polit & Beck 2008:180).

## **3.8 CONCLUSION**

This chapter outlined the research design and methods and ethical considerations that were followed in conducting this study. In the next chapter, analysis of data, presentation and description of the findings will be discussed.

## **CHAPTER 4**

### **ANALYSIS, PRESENTATION AND DESCRIPTION OF RESEARCH FINDINGS**

#### **4.1 INTRODUCTION**

In the previous chapter the research method and design were discussed. This chapter presents the research findings.

The purpose of the study was to design support guidelines for the nurses who care for patients who attempt or successfully commit suicide whilst admitted at a general hospital.

#### **4.2 RESEARCH OBJECTIVES**

The objectives of this study were to

- explore the experiences of nurses regarding incidents of patients committing suicide in hospital
- describe the effects of suicide events on nurses caring for patients who attempted or successfully committed suicide
- design support guidelines for the nurses who care for patients who commit suicide whilst admitted in hospital

#### **4.3 DATA COLLECTION PROCESS**

Data was collected from six nurses, that is, two professional nurses, two enrolled nurses and two enrolled nursing assistants working at the selected general hospital in Gauteng Province, through individual in-depth interviews. The participants were included in the interviews according to their eligibility criteria as explained in chapter 3 of this study. The participants were referred to as P1-P6 (P meaning Participant) in the

order in which the interviews were conducted. The interview dates and times were arranged with the participants prior to data-collection dates. The interviews were conducted during days that the participants were not on duty in order to avoid distracting the participants from their normal ward duties.

The participants provided written consent to be included in the study. Separate interviews with the six participants took place in a private office within the hospital.

### **Typical challenges encountered during the interviews**

The following were challenges that the researcher encountered during the interviews:

- The researcher took off the receiver from the landline before the interview started, however the telephone rang during an interview, the phone was not answered and the participant lost focus. The researcher apologised to the participant and disconnected the phone from the hook.
- One participant was affected emotionally and the researcher had to stop with the interview, counselled the participant and referred her to employee assistant wellness practitioner.
- The researcher was careful about the participants' emotions as the study might expose deep seated fear and anxiety that was previously repressed and could lead to emotional harm. An untoward emotional reaction that happened during an interview was handled by putting an interview on hold and referring the participant to the clinical psychologist for counselling.
- Emotions of participants affected the interviewer to such an extent that she consulted her psychologist for debriefing.
- One interview exceeded the agreed upon time. The researcher had indicated that the interviews may take up to an hour. After indicating to a participant that the hour was up, there was more that the participant wished to share.

#### 4.4 DATA ANALYSIS

Data analysis was done following a generic qualitative data content analysis whereby:

- Participant's verbatim transcript was read to acquire a sense of the whole.
- The researcher began by searching for broad categories that emerged from collected data.
- The researcher derived meaning units from narrative material whereby the researcher went back to narrative material with categories in mind to see if materials really do fit and then refined categories as necessary (Polit & Beck 2008:515).
- Similar categories were clustered into broad themes.

The researcher moved to a phase of reading and rereading the transcripts to identify and highlight the participants' experiences regarding patients who attempted or successfully committed suicide. Significant phrases and statements were extracted from the transcripts that together formed the whole meaning of the experiences regarding patients who attempted or successfully committed suicide. The researcher analysed each transcript to identify statements that told each participant's story of their experience.

The following is an example of how significant statements were identified and distilled from an interview (transcript one):

*"Patients who commit suicide appear normal but at the end of the day they do something that nobody thought they will do, they never pre-empt what they will do so no-one predicts, when they do this it becomes traumatic, as a nurse you ask yourself, what have you done wrong, what is it that you omitted, what is it that you could have done to prevent such an occurrence. It is a very difficult experience to leave with".*

**Table 4.1 Significant statements and formulated meanings**

<b>Significant statement</b>	<b>Formulated meaning</b>	<b>Theme</b>	<b>Category</b>
<i>"Patients appear normal"</i>	Suicidal patients hide their intentions	Nurses perceptions of Suicidal patients	Unpredictable suicidal patients
<i>"Never pre-empt what they want to do, no one predicts"</i>	Patients withhold information from nurses		Nurse-patient relationship

Each significant statement relating to the description of the experiences of nurses regarding patients who attempted or successfully committed suicide in hospital was studied very carefully to get a sense of its meaning. Formulated meanings were developed, taking into account the statement preceding and following each significant statement. Once the researcher had formulated meanings for all the significant statements, the researcher then began arranging the formulated meanings into theme clusters.

#### **4.5 DATA FINDINGS**

Five themes emerged from the findings of this study and categories were formulated (refer to table 4.2).

**Table 4.2 Themes and categories**

<b>Themes</b>	<b>Categories</b>	<b>Meaning units</b>
<p><b>Theme 1</b> The working environment</p>	<p><b>Category 1.1</b> Location of the unit and infrastructure</p> <p><b>Category 1.2</b> Lack of a therapeutic environment</p>	<p>The physical environment of the unit is not safe for suicidal patients</p>
<p><b>Theme 2</b> Nurse's descriptions of suicidal patients</p>	<p><b>Category 2.1</b> Inadequate patient history</p> <p><b>Category 2.2</b> Unpredictable patient behaviour</p> <p><b>Category 2.3</b> Self-destructive behaviour</p>	<p>Patients give history that lead to medical diagnosis instead of mental illness</p> <p>Patient withhold their intentions from nurses</p> <p>Patients commit suicide to kill themselves</p>
<p><b>Theme 3</b> Nurses reactions to attempted or successfully committed suicide</p>	<p><b>Category 3.1</b> Self -blame</p> <p><b>Category 3.2</b> Feelings of guilt</p> <p><b>Category 3.3</b> Emotional trauma and depression</p>	<p>Nurses blame themselves for the occurrence</p> <p>Nurses feel they failed the patient therefore they are responsible for the outcome</p> <p>Nurses are emotionally affected by an attempted or successful suicide</p>
<p><b>Theme 4</b> Fear of patient's family response to loss of their loved one</p>	<p><b>Category 4.1</b> Family reactions to loss</p> <p><b>Category 4.2</b> Fear of losing a job/career</p>	<p>Nurses are concerned about the family's response to attempted or successful in-patient suicide.</p> <p>Nurses' fear of losing their jobs Decision of the employer about the future of involved personnel</p>

<b>Themes</b>	<b>Categories</b>	<b>Meaning units</b>
<b>Theme 5</b> Support structures	<b>Category 5.1</b> Support from hospital management	Management to recognise nurses that nursed patients who attempted or successfully committed suicide
	<b>Category 5.2</b> Counselling of staff	Nurses need debriefing and counselling session

#### **4.6 DESCRIPTION OF DATA**

After extensive analysis and reflection, five themes emerged from this study. These themes are described and illuminated by narrative comments from the participants in this study. Presentation of the findings follows the discussion of each theme, as it is asserted that integrating the findings and the discussion is an appropriate method for encapsulating the essence of the phenomenon under investigation. Existing literature was used to support or disapprove the findings.

##### **Theme 1: The working environment**

The working environment emerged as a theme in relation the location of the unit and infrastructure. The participants indicated that the environment is not safe for both the patients and the personnel. The unit is situated on the third floor of the building; is twenty-five bedded with four cubicles accommodating four beds, six single cubicles and two cubicles accommodating two beds. The cubicles are divided by brick walls, windows have big glass window panes without burglar proofing. The unit has two wings, at each wing there is an exit door. Exit doors are not always locked as they are regarded as emergency exit doors. The sluice room of this unit had a linen shutter without a key. At each four bedded cubicle there is a glass door leading to the balcony, which was not locked due to non-availability of keys for the door. Sadock and Sadock (2007:905) indicate that the unit where suicidal patients are admitted should be located near the nurses' station; it must have shatterproof windows and must be locked. Contrary to the mentioned requirement, suicidal

patients were admitted in any available bed within the unit in this study. This practise posed a threat because patients broke windows and jumped through them from the cubicles far away from the nurses' station. One patient hanged himself on the curtain rail in one of the single rooms. The location at which the unit is situated and the infrastructural challenges were regarded as threats to patient safety as indicated by the following participant's narrative.

*"This unit is a threat to patient safety, look windows are very big, the patient I nursed broke the window of a cubicle that was not having a patient. All we heard was a sound of a breaking window and thereafter the patient flew down like a bird. That was shocking I didn't even want to go to lower ground to see that patient the way I was shocked, shivering ... it is an experience that I do not wish"* (Participant 1).

### **Category 1:1: Location of the unit and infrastructure**

Regarding the physical environment, the position of the ward was considered a high risk. The layout of the unit was also a concern because the unit is divided into cubicles and some cubicles accommodate one patient and the cubicles are divided with a brick wall which caused nurses not to see what was happening in the next cubicle. The linen shutter that was not locked in the sluice room was reported as a high risk.

*"Mh!! the linen shutter became a tool of committing suicide, one patient just opened that linen shutter and went through, I didn't believe it, I still cannot believe it even today ... just imagine from third floor to lower ground"* (Participant 2).

*"Yho!! You do not know what is going on here. This unit is a hazard, keys to emergency exit doors are missing and those doors remain unlocked, anytime patients go through those doors and you look for them and never find them. I remember this patient that we noticed that he is missing in the evening, we looked for him and we did not get him. In the morning we were called by security officer at first floor only to find out the patient*

*jumped from third floor and fell on the roof of first floor building ... taking a deep sigh ... his face was severely injured” (Participant 4).*

The participants indicated that the environment was not conducive for patient safety, as there were many areas through which the patients could jump through and throw themselves on the ground. The glass windows that are in the unit were also seen as a high risk as some patients used them to injure themselves. Curtain rails were also seen as threat to patients because when patients were ready to commit suicide they used any available tool.

*“Curtain rails for that ward are too high hence the patient successfully hanged himself in those rails. That ward is a health hazard to patients, those patients that are intending to commit suicide can find that unit as a tool of committing suicide” (Participant 2).*

*“Doors leading to the balcony are not locked, keys are not available. Patients easily access the balcony. Suicidal patients can easily jump from the balcony and thereafter we will have to account, really patient safety is compromised” (Participant 3).*

### **Category 1.2: Lack of a therapeutic environment**

Therapeutic environment refers to purposeful use of people, resources and events in the patient’s immediate environment to ensure safety and promote optimal functioning in activities of daily living (Kneisl & Trigoboff 2013:250). The participants indicated that there was no safe and therapeutic environment for the patients; confused patients were roaming around the unit. Even patients that were admitted with signs of depression were not admitted in safe environment where they would be observed closely. Patients were admitted in normal cubicles with big windows, hand-washing basins with mirrors above them.

*“This patient was treated as any medical patient, should I have known I could have removed things such as bedside lockers, drip stands and anything that I could have suspected that she might use in that cubicle to*

*commit suicide and just left her with a mattress and a blanket, I never created a conducive environment for this patient at all and that haunts me on daily basis. Crying ... this institution exposes us to risks even linen shutters of this ward are not locked they do not have keys, but when these incidents happen I have to account, the fact that the unit is not safe is not even looked into” (Participant 5).*

## **Theme 2: Nurses descriptions of suicidal patients**

The participants described patients who attempted or succeeded in committing suicide as patients who withheld their intentions from nurses. The nurses' description of suicidal patients included inaccurate patient history and unpredictable patient behaviour. It was indicated by the participants that the patients never demonstrated any suspicious behaviour. The patients behaved normally, neither mood swings nor depression was observed from them. The behaviour of these patients supported the literature which states that suicidal patients who suddenly are at peace with themselves have reached a decision to commit suicide (Sadock & Sadock 2007:905).

### **Category 2.1: Inadequate patient history**

History taking is an interview that is conducted to obtain information in order to make assessment of patients' diagnosis and formulate a management plan. This interview should be done in a careful and rigorous manner so that the history obtained and the observations made guide the clinician towards a professional diagnosis (Baumann 2008:68). Information obtained helps nurses to understand the nature of the symptoms and what they mean to the patient. The participants indicated that some of the patients who attempted or successfully committed suicide did not give accurate history at casualty (emergency unit) or outpatient department; and that led to patients being admitted with inaccurate diagnosis. The patients cared for in the units of this study were not mentally ill patients, but were patients with medical conditions. The participants were of the opinion that accurate history was not obtained from the patient or family. Inaccurate history taking can be attributed to the time limit in emergency departments (Baumann 2008:68).

*“Proper patient diagnosis from the point of entry (casualty and out-patient Department) should be made and correct treatment should be ordered. Doctors should order mild anti-psychotic drugs for patients with psychosis or confusion to reduce their activities rather than admitting patients with medical conditions and giving them antibiotics that do not help at all”* (Participant 6).

The participants reported their dissatisfaction with improper patient diagnosis due to incorrect history. The participants indicated that accurate history given by patients or relatives, could have contributed to a different management plan of the patient.

*“Eish ..., I can assure you if these patients were properly diagnosed at casualty/out-patient department they were never going to be admitted in this unit and you will not be doing this study (laughing)”* (Participant 6).

## **Category 2.2: Unpredictable patient behaviour**

The findings indicated suicidal patients did not demonstrate any suspicious behaviour, they withheld their intentions, and they behaved normally like any other patients. The participants indicated that these patients were very unpredictable.

*“Patients who attempt or successfully commit suicide appear normal but at the end of the day they do something that nobody thought they will do, they never pre-empt what they will do so no-one predicts, when they do this it becomes traumatic, as a nurse you ask yourself, what have you done wrong, what is it that you omitted, what is it that you could have done to prevent such an occurrence”* (Participant 1).

The findings indicated that the participants were of the opinion that suicidal patients do not pre-empt their plans, they just conclude in their minds and commit suicide without considering the implications their actions will have on the nursing personnel that was caring for them. The participants stated that the methods with which the patients attempt or successfully commit suicide indicated that the patients no longer cared about

their lives. For example they jumped through windows, hanged themselves or threw themselves through the linen shutters. This resulted in death or fatal injuries.

*“The patient that went through the shutter sustained bilateral femur fractures, head injury everything was just broken ... (taking a deep sigh). Nobody who cares about her life would have done that, that corpse was crushed, I always experience visual hallucinations and ask myself ... Can a human being hate herself that much that she would crush her body?”* (Participant 5).

From the narrative it is also evident that the manner in which the deceased body looked like traumatised the nursing personnel involved.

*“It is a shocking, depressing and frustrating experience. I was stressed, my heart was painful and I could not sleep that day. I was just rolling in my bed seeing the picture of the patient. Yho!! that is terrible. I really do not know how I survived that traumatic pain”* (Participant 1).

### **Theme 3: Nurses reactions to attempted or successfully committed suicide**

People react in different ways to different situation. This theme illustrated different reactions of the nurses to patients who attempted or successfully committed suicide. The participants indicated that incidents of suicide affected their emotions negatively. The participants had feelings of guilt, blaming themselves and lost confidence in their patient care. Some participants verbalised that they developed visual hallucinations, emotional trauma and depression.

#### **Category 3.1: Self-blame**

The participants blamed themselves for the loss of patients; they indicated that they felt responsible for patients who successfully committed suicide.

*“I blamed myself I could not sleep, I felt like I have killed the patient. I felt like I should have suspected when the patient wanted me to leave him*

*with a vial of insulin, I felt like the observation that I did the whole night was not enough” (Participant 4).*

*“I felt like I have failed the family because they trusted me with their family member that their member will get help. Now the patient jumped and committed suicide under my care” (Participant 6).*

*“Feels like whatever was done for the patient was not enough because now the patient has chosen to die than to be taken care of” (Participant 1).*

The findings indicate that there were missed opportunities that the nurses had, but failed to notice that the patients were intending to commit suicide.

### **Category 3.2: Feelings of guilt**

The participants reported that they felt guilty, and took responsibility for the patients that successfully committed suicide.

*“Feelings of guilt and inadequacy overwhelmed me, I started asking myself what could I have done better should I have known that the patient was going to brutally kill herself like that. Hopelessness and uselessness comes to my mind every time I think about that incident” (Participant 6).*

*“I felt like I did not do anything for the patient, I did not know what to do. I felt like I’m the only stupid person in the world” (Participant 2).*

*“Anxious ... I leave in fear I do not want to see a patient roaming around. Yho!! I will never forget that day it is like happening today. Oh!! No that I do not wish even for my worst enemy, it is very sad. To think that I was at work on that day and I couldn’t help the patient breaks my heart it means (crying) ... I’m a failure” (Participant 2).*

The findings demonstrate signs of post-traumatic stress disorder by the participants, as they showed fear and helplessness. The participants reported that they felt guilty about in-patient suicide and these feelings affected them negatively.

### **Category 3:3: Emotional trauma and depression**

In-patient suicide affected the nurses emotionally; they sometimes got depressed due to the flashbacks of the incident in their minds. The participants indicated that it was not easy to cope after the incident, some verbalised that they could not sleep on the day of the incident.

*“When she jumped from third floor I was shocked, scared, frustrated and just discouraged. That day was just a disaster. I started asking myself why this did happen whilst I am on duty. That experience is traumatising, I do not even wish my enemies should go through that. It is a very frustrating experience’ (Participant 1).*

*“I was stressed, my heart was painful and I could not sleep that day. I was just rolling in my bed seeing the picture of the patient” (Participant 1).*

*“This was a tragedy, losing a patient through suicide especially a patient throwing herself into the ground is a very depressing situation. The patient’s death affected me very bad. Normally patients are supposed to die peacefully and with dignity, eish!! That was very bad, very very bad” (Participant 6).*

*“It was traumatising and depressing, I did not want to talk about the incident. Even at home my 5 year old asked me about what he heard at pre-school about my workplace and I just became irritable. I’m still on anti-depressants now. I really do not want to talk about this incident because I even dream about it” (Participant 2).*

The participants indicated that they re-experienced the suicide incidents. They also indicated that they did not want to talk about the incidents because it stressed them and

it affected their concentration. One participant indicated that she is on anti-depressants since the incidents.

#### **Theme 4: Fear of family's response to loss of their loved one**

In-patient suicide is not expected by the patient's relatives and when it happens relatives react in different ways such as anger, loss of trust to health care establishments and workers; and blame themselves for not doing things differently.

##### **Category 4:1: Family reactions to loss**

Participants indicated that when suicide was committed by patients that were under their care, they were afraid of the family's reactions to loss. Different reactions were demonstrated by families and those reactions stressed the nurses, as some relatives blamed them for the death of their loved ones. Nurses were labelled as cruel.

*"Family came and asked for answers wanting to know what happened to their family member. Family demanded answers from us as nurses and at that time we didn't have an answer because we didn't even know that the patient was intending to kill himself but relatives behaved as if we knew all along about the plans of the patient" (Participant 1).*

The findings showed that family members reacted negatively to the loss of their loved ones through suicide. The families apportioned the blame to nurses. However, a participant indicated that one family was honest enough to tell the truth that the patient attempted to commit suicide several times before. The family did not blame the nurses as they were aware of the suicidal risk.

*"At least the patient's relatives were supportive to me, they indicated that this was the third time that their brother tried to commit suicide it means now it became a success" (Participant 4).*

## **Category 4.2: Fear of losing a job/career**

According to the findings of this study, the families reacted negatively to in-patient suicide, apportioned blame to nurses and also threatened the nurses about losing their job. The participants indicated that some patients' relatives threatened them about ensuring that they will never work again as nurses because they are not caring at all; instead patients prefer to kill themselves than to be cared for by nurses.

*"I remember this woman who pointed a finger at me and said you are responsible for my brother's death, my brother will not just kill himself without you provoking him actually your cruelty caused my brother to run away from you, he chose to jump through a window than to be taken care of by you. I will make sure that you will never work again"* (Participant 6).

The participants were afraid that the Department of Health and hospital management would also blame them for the adverse events. The findings indicate that the participants were concerned about the decision that will be taken by the nursing regulating body, the SANC, about their future in the nursing profession if the incidents were reported. The participants were concerned about being removed from the SANC register.

*"Mh!! I thought of being removed from the South African Nursing Council register, the whole career will change"* (Participant 5).

## **Theme 5: Support structures**

Nurses provide emotional support to patients and family members. When nurses are exposed to emotional trauma they also need to be supported. The support structures included support from senior nursing managers and the need for counselling services for the affected nurses.

## Category 5.1: Support from hospital management

The participants indicated that they received overwhelming support from nursing management.

*“There was good support, nurse managers came in the unit and they encouraged us and reassured us. They spent most of the time in the unit supporting us; they did not judge us at all. Senior Nursing Service Manager was not in the institution when the incident happened but she called and encouraged staff. That was a great relief. Their support made us understand the tragedy. Support made a difference as they understood the situation. Their presence in the unit encouraged me”* (Participant 1).

*“An empathetic attitude was observed towards directly affected nursing personnel. Nurse Managers were objective, they did not judge us”* (Participant 2).

One participant indicated that she never got any form of support from management instead her colleague was called by the nursing manager and informed that she must get ready with answers because the relatives of patients are looking for answers. This participant was very angry with management because she was not supported at all, she was working at night and that day she could not sleep at all and yet she was expected to come to work and run a 25-bedded unit as a staff nurse.

*“There was no support at all, in the morning of the incident none of nursing managers came to the scene of incident instead the Nursing Service Manager called the Nursing Assistant that I was working with and told her that the family of the patient will need answers and we have to give those answers and she told her that she must tell me to write the statement because she does not understand how can a patient hang himself with linen on a curtain rail and we did not hear him it means we were sleeping. There is absolutely no support that I got from nursing management not at all”* (Participant 4).

## **Category 5:2: Counselling of staff**

The findings indicate that the nurses needed debriefing and counselling sessions while dealing with patients who attempted or successfully committed suicide.

*“Counselling was not done, actually I hoped that nurse managers would come to our unit or call us to the boardroom and find out from us what happened, how do we feel about it and how are we coping with the incident or at least be referred to psychologist at hospital cost, my expectations were not met instead we were expected to continue working as if nothing strange happened” (Participant 4).*

The results further indicate that personal psychological needs were not taken into consideration and also not attended to. Emotional needs of staff were not considered or attended to. There was no employee assistant programme in the institution; however, social workers and clinical psychologists were providing counselling for patients in this institution. The participants were not referred for counselling. The nurses indicated that they needed to be appreciated than blamed.

*“The least that she could have done would have been to appreciate us for the hard work we are doing nursing 25 patients whilst we are only two in a medical ward. In my situation I never received any appreciation at all” (Participant 4).*

The findings showed that management underestimated the power of appreciation, as according to participants appreciation motivates them. However, that was not happening, as a result the nurses' morale became low and that led to poor performance.

## 4.7 DISCUSSION OF THE RESULTS

### Theme 1: The working environment

The study revealed that a non-therapeutic environment contributes to in-patient suicide. The position of the unit and its infrastructural challenges were highly regarded as threats to patient's safety. Unlocked linen shutters, emergency exit doors and big glass windows were reported as routes through which patients used to commit suicide. The findings revealed that the working environment was not free of health hazards and therefore was not safe for both the patients and the nurses.

The environment in this study is in contrast with literature, according to Uys and Middleton (2010:262), who state that the environment should be safe for both the patient and nurses. A qualitative study done in the USA revealed that patients describe a hospital as a refuge where they are among people who are like them, where they are protected from their own self destructive tendencies and where hope for their future is communicated to them (Ballard et al 2008:274). However, in this study the findings showed that patients used the hospital as a place where they fulfilled their self-destructive behaviour by successfully committing suicide. In this environment which involved caring for in-patients who attempted or successfully committed suicide, it was important to note the physical environment in which the nurses worked. The unit infrastructure was such that the patients were admitted in the medical wards with big windows, situated on the third floor of the building. In the said unit, there were no safety rooms for confused or depressed patients. The position at which the wards are situated is risky and it exposes patients to attempting or committing suicide by jumping from heights.

A study conducted by McGuire (2011:35) revealed that weaknesses in environmental safety were the root cause of reported suicides. In the same study it was found that while patients in psychiatric units commonly commit suicide by hanging, those in the medical wards commonly jump from heights. The findings concur with the information that was given by participants in the current study, who indicated that four patients committed suicide during the study period, where one patient hanged himself and three patients jumped through windows from the third floor of the medical unit.

A safe environment can be created by restricting access to heights, preventing rooftop access, locking doors and closing windows. Removing belts, shoelaces and other materials that can be used for hanging, as well as removing interior doors and any other structures that can be used as anchor points will eliminate potential environmental hazards. Contrary to the mentioned prevention strategies, at the study setting the environment was defined as unsafe for prevention of in-patient suicide (McGuire 2011:35).

## **Theme 2: Nurses descriptions of suicidal patients**

According to findings participants perceived that suicidal patients had unpredictable behaviours, not trusting and withholding their intentions to commit suicide. It was evident that the participants did not predict that the patients would commit suicide because no suspicious behaviour was demonstrated by the patients. Hence, it was not possible for the participants to prevent the occurrence of in-patient suicide. Powell, Geddes, Deeks, Goldacre and Hawton (2000:266) indicate that psychiatric hospital in-patients are known to be at high risk of suicide, yet there is little reliable knowledge of risk factors or their predictive power.

According to Sadock and Sadock (2007:900), suicidal patients who succeed in committing suicide have a history of previous suicide attempt, and patients usually succeed when they attempt suicide for the second time. This study revealed different information because some of the patients that successfully committed suicide had no history of attempted suicide before and they were admitted for medical conditions. Ho and Tay (2004:39) in their study on suicide in general hospitals in Hong Kong found that patients had been admitted because of physical problems.

The participants measured the extent of self-destruction by the method used by the patient to commit suicide. It is also evident that the sight of the deceased bodies after the incidents traumatised the nursing personnel. The outcome of suicidal patient's self-destructive behaviour affected the nurses negatively because they became shocked, frustrated, traumatised and depressed (Collins 2003:161).

Self-destructive behaviours are maladaptive measures an individual uses to restore inner equilibrium when overwhelmed or unable to cope with stressful life events. People attempt to commit suicide thinking that they can take away an unbearable emotional pain. The finding of this study could not confirm the reasons for suicide because the patients successfully committed suicide without presenting a suspicious behaviour (Kneisl & Trigoboff 2013:509).

### **Theme 3: Nurses reactions to attempted or successfully committed suicide**

The study showed that nurses blamed themselves for in-patient suicide, felt incompetent, inadequate, guilty and responsible for the patients' death. The feeling of the participants was that they did not do enough for the patients. The nurses blamed themselves for not having taken accurate patient history and also for not knowing the intentions of the patient. They felt that they failed both the patient and the family and this led to self-blame.

Guilt is an emotional state associated with self-reproach and the need for punishment. In psychoanalysis' it refers to a feeling of culpability that stems from a conflict between the ego and superego. It has normal psychological and social functions, but special intensity or absence of guilt characterises many disorders such, as depression and anti-social disorder (Sadock & Sadock 2007:278).

Uys and Middleton (2010:400) indicate that common reactions experienced by caregivers are guilt, anger, self-blame, sadness, fear and feelings of professional failure.

Support for staff members is critical a patient suicide incident, demonstration of a caring attitude by senior managers promotes a sense of belonging to the affected employees. When a suicide incident occurs, nurses review their reasons for becoming nurses. Thoughts of reconsidering career change are common reactions among nurses (Kneisl & Trigoboff 2013:509). The participants in this study presented the same reactions during data collection of the current study however none of the participants indicated change of the career except that they were more concerned about the decision that will

be taken by the employer (Department of Health) and the regulating body (SANC) about their career in the near future.

#### **Theme 4: Fear of family's response to injury or loss of their loved one**

According to the findings the nurses were afraid of the family's reactions to their loss. Different reactions were demonstrated by families and those reactions caused the nurses to be stressed, as some relatives blamed nurses for the death of their loved ones.

According to Sadock and Sadock (2007:907), suicide survivors refer to those who have a lost a loved one to suicide, not suicide to one who attempted suicide and lived. The toll on suicide survivors appears greater than those that by other deaths, mainly because the opportunities of guilt are so great. Survivors feel that the loved one intentionally and willingly took his/her life and that if only the survivor had done something differently, the decedent would still be alive.

Nurses feared loss of their job when in-patients committed suicide. Their concerns were that the Department of Health will apportion blame on them, and other contributing factors would not be considered. This study showed that nurses understood the functions of the SANC and the Department of Health, hence, their concern was about the decisions that would be taken by the SANC and the employer. Loss of job was their greatest fear as nurses thought of worst decisions such as being de-registered from the SANC register.

#### **Theme 5: Support structures**

Support received from nursing management motivated nurses that were involved in incidents of successful in-patient suicide. The participants that were supported by management coped better with the incident than those not supported.

The findings indicated that participants that were supported by management accepted and coped well with the incident, while those who received no support did not accept

the incident and remained angry with the senior nursing service managers that showed no remorse to them in relation to the incident.

Supportive activities refer to all activities that merely maintain what is already there without any demands being made to a person. Nurse managers supported nurses by being there without demanding anything from nurses; however, they never provided any counselling or debriefing.

According to the findings the nurses needed debriefing and counselling sessions while dealing with patients who attempted or successfully committed suicide. It was evident that when the incidents occurred the patient's family threatened nurses and promised them to ensure that they will lose their jobs and they held nurses responsible for the death of their loved ones through suicide. The threat from family members frustrated nurses and they needed to get reassurance from management.

#### **4.8 CONCLUSION**

In this chapter the findings of the study were presented and discussed. Literature was used to discuss and support the findings. In the next chapter, chapter 5, conclusions and recommendations; and the support guidelines will be presented.

## CHAPTER 5

### CONCLUSIONS AND RECOMMENDATIONS

#### 5.1 INTRODUCTION

The aim of this chapter is to provide concluding remarks, limitations and recommendations. The purpose of this study was to design support guidelines for the nurses who care for patients who attempt or successfully committed suicide whilst admitted in a general hospital, in Gauteng.

#### 5.2 RESEARCH DESIGN AND METHOD

Individual in-depth interviews were conducted from a sample of different categories of nurses who worked in medical ward; to explore their experiences. The study focused on experiences of nurses regarding attempted or successful in-patient suicide. A qualitative data analysis was done. The findings indicated that the nurses experienced negative emotions and feelings regarding attempted or successful in-patient suicide. The findings were used to design guidelines to support the affected nurses in their work environment.

#### 5.3 CONCLUSIONS

Themes that emerged were as follows:

##### **Theme 1: The working environment**

The working environment was identified as a theme with regard to the location at which the medical units are situated. Units are situated on third floor, a risky level for patients intending to commit suicide by jumping from heights. The findings of this study indicated that the structure of the unit is not suitable for management of suicidal patients. Neville (2013:35) recommends that suicidal patients should be nursed in an environment that is free from hazards that might be used as methods of committing suicide.

## **Theme 2: Nurses' descriptions of suicidal patients**

Suicidal patients are described by the nurses as individuals who do not express their feelings and intentions. The decisions that are taken by the suicidal patients about their lives shocked the nurses that cared for them whilst admitted in hospital; including the patients' families. Some patients seemed at peace with themselves just before they committed suicide which nurses interpreted as a way to avoid close observation from nursing personnel. The findings indicated that suicidal patients did not pre-empt their plans, and did not consider the implications their acts would have on the nursing personnel that was caring for them; and their families (Norheim, Grinholt & Ekeberg 2013:17).

## **Theme 3: Nurses reactions to attempted or successfully committed suicide**

The findings revealed that the nurses were negatively affected by the experiences of caring for suicidal patients. It follows that the nurses had to live with those feelings which resulted in others being treated with anti-depressants. However, the medications only suppressed the feeling. This indicated the need for support guidelines for the nurses to cope with their experiences of suicidal patients.

## **Theme 4: Fear of family's response to injury or loss of their loved one**

Kneisl and Trigoboff (2013:524) stated that suicide is denied by families who wish to avoid feelings of shame or being blamed for death. Suicide exacerbates dysfunctional family dynamics such as scape-goating or blaming other family members. The findings of this study revealed that scape-goating is directed at the nurses when in-patient suicide occurs.

## **Theme 5: Support structures**

The findings from this study revealed that there was no employee wellness programme in the institution; as a result affected nurses were not referred for formal counselling and debriefing. Those participants that could not cope with the incident consulted

psychologists for counselling at their own expense, whilst others were treated with antidepressants.

#### **5.4 GUIDELINES TO SUPPORT NURSES CARING FOR SUICIDAL PATIENTS IN A GENERAL HOSPITAL**

Participants underwent a variety of experiences during management of in-patient suicide incidents, and the emotions and feelings were mostly negative. It was clear that there were no guidelines on assessment, diagnosis and management of suicidal patients. Therefore, the nurses needed guidelines that will provide direction on suicide management in a general setting

Five guidelines are presented based on the findings of this study. The negative experiences described by the nurses in this study were considered to be problems; from which the guidelines are formulated. The guidelines are provided with rationale to support their need to be designed. The guidelines are referred to the National Department of Health, Gauteng Province Department of health, the management of the hospital that took part in this study, the SANC and also the nursing staff in general.

##### **5.4.1 Problem: Unsafe working environment**

*Guideline 1: Create of a safe working environment for provision of quality nursing care for patients with mental illness in the general setting.*

- Admit patients in a cubicle that is close to nurses' station for easy access and observation; eliminate all environmental hazards such as pills or other harmful objects in patient's possession.
- Convert single rooms close to the nurses' station into seclusion rooms.
- The converted seclusion rooms should have shattered proof windows; the infrastructure requirements in forensic psychiatric observation units should be followed.
- Ensure patient safety by relocating medical units from upper floors to ground floor.

- Ensure adequate privacy and control access points by locking exit doors and linen shutters (The keys for the locked doors should be kept and controlled by the shift leaders)
- Replace glass windows with shattered proof windows in all cubicles of medical units.

Rationale: to improve patient safety through effective patient assessment and provision of safe environment for patients.

#### **5.4.2 Problem: Inadequate history taking from suicidal patients**

*Guideline 2: Ensure accurate or comprehensive history taking and proper patient assessment and diagnosis at casualty and out-patient departments on admission, and continuously whilst in the unit.*

- Demonstrate a professional, non-punitive attitude when obtaining history from the patient.
- Engage the patient and empathically allow the patient to express his feelings and thoughts during admission.
- Mental state evaluation of the patient should be done preferably by personnel trained on mental health.
- Do physical examination to exclude existing symptoms of self-destructive behavior such as wrist cut.
- Observe the mood and attitude of the patient to establish changes.
- Design policy on patient assessment and diagnosis of suicidal patients in casualty, out-patient departments and medical units. Enforce adherence by all staff members.
- Advocate for multidisciplinary team approach (doctors, nurses, allied personnel and hospital management) to design a guideline on management of suicidal patients in a general hospital, and enforce implementation of such guideline by clinicians.
- Train nursing staff in suicide risk assessment and management
- Include an assessment of mental state in all admissions (holistic approach)

Rationale: to ensure early diagnosis and correct management of suicidal patients

#### **5.4.3 Problem: Lack of support for nurses following in-patient suicide incident**

*Guideline 3a: Conduct of debriefing sessions with the affected nurses after the untoward event by the nursing unit manager in consultation with the hospital authorities.*

- Non-punitive supportive approach from management
- Allow the affected staff to express their emotions and feelings about the incident.
- Find out from them if the incident could have been prevented, if so, how.
- Refer the affected nurses for formal counselling to professional counsellors where necessary.
- Establish open communication channel between staff and nursing management, staff should be considered as important source of information and therefore they should be fully informed and involved.
- Encourage staff to demonstrate a positive attitude to patients through flexibility, vigilance, friendliness and friendly firmness whilst caring for patients

*Guideline 3b: Refer the affected nurses to employee wellness assistant Programme within the hospital.*

- The hospital to revive the employee and wellness assistant programme for nurses within the hospital and refer such incidents.
- Develop partnership with local faith based organisations and refer affected employees, if they require and prefer these services.
- Discuss with the local faith based forum chairperson about the procedure that will be followed when such incidents occur.

Rationale: to provide counselling and to give the affected staff an opportunity to express their feelings and experiences about the impact of the incident.

### **5.4.3 Problem: Minimal knowledge on management of suicidal patients in general medical units**

*Guideline 4: Train nurses working in medical units on management of patient with altered mental function.*

- Develop a community program that will empower families on dealing with loss through in-patient suicide.
- Provide in-service training to staff and families on coping with attempted and committed suicide.
- Source a psychiatric specialist from nearest psychiatric institution to give in-service training to professional nurses working in Casualty and outpatient departments, and medical units on mental status assessment of medically ill patient to exclude mental illness

Rationale: to empower nurses through knowledge with information on management of suicidal patients and to provide activities that nurse can implement to empower the families of patients who committed suicide.

### **5.4.5 Problem: Patients families' negative attitude towards health care workers**

*Guideline 5: Involve family in management of their relative.*

- Inform relatives about the unpredictable behaviour of suicidal patients.
- Refer relatives to clinical psychologist at hospital cost for psychotherapy.

Rationale: to encourage burden sharing and to provide support to the patient's family members

## **5.5 GENERAL CONCLUSIONS**

This chapter summarised findings, described limitations and made recommendations for improved patient management and future research. The study was conducted to explore and describe the experiences of nurses regarding attempted or successful in-

patient suicide in Gauteng and to develop guidelines that will help them to manage suicidal patients. The guidelines were developed based on problems derived from the experiences of nurses who cared for patients that attempted or successfully committed suicide whilst admitted in the general hospital.

## **5.6 RECOMMENDATIONS**

The following are the recommendations following this study:

### **5.6.1 Recommendations for further research**

The researcher recommends the following research:

- Experiences of families who lost relatives through suicide whilst admitted in a general hospital.
- The prevalence of in-patient suicide in general hospitals in Gauteng Province.

### **5.6.2 Recommendations for nursing practice**

- Develop a policy on prevention of in-patient suicide in general hospital.
- Develop a protocol on management of suicide patients in general hospital.
- Establish Outreach programme services from psychiatric hospitals to general hospitals to provide support on management of patients with mental disorders.
- Develop a debriefing strategy for employees who experience in-patient suicide.

## **5.7 CONTRIBUTIONS OF THE STUDY**

The study will contribute towards greater understanding into the experiences of nurses regarding in-patients who attempt or successfully commit suicide and the nurse's reactions to such incidents. The researcher will communicate the findings and recommendations to the health care institution's management and to other relevant stakeholders in nursing. The findings will, be disseminated through presentation at the relevant workshops and conferences, and through publication in accredited nursing and medical journal relevant to the target readers.

## **5.8 LIMITATIONS OF THE STUDY**

Limitations of the study were that the study was conducted in one general hospital in Gauteng and therefore findings cannot be generalised to other general hospitals.

The sample was small; only six participants were included in the study. If a bigger sample was used, the results might have been different. Also, the findings would be different if the study was conducted in a mental hospital or psychiatric unit.

## **5.9 CONCLUDING REMARKS**

The findings of this study clearly indicate that there are no guidelines on management of suicidal patients in this general hospital. Patients were admitted with medical conditions following competency in assessment, diagnosis and management of medical conditions. The outcomes of this overlooked the altered mental health status of the patients, which led to incidents of in-patient suicide, and the nurses bearing the negative consequences of the incidents. The guidelines are designed in order to enable hospital to provide effective support to the nurses caring for these patients and to reduce in-patient suicide in general units.

An unexpected positive outcome from this study was that the participants took the interview session as a debriefing session, where they managed to indicate their concerns without prejudice. The interviewer demonstrated sympathy with the participants as they verbalised their experiences.

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## ANNEXURE A

### Approval of research study by Higher Degrees Committee of the Department of Health Studies, UNISA



**UNIVERSITY OF SOUTH AFRICA  
Health Studies Higher Degrees Committee  
College of Human Sciences  
ETHICAL CLEARANCE CERTIFICATE**

**HS HDC/129/2012**

Date: 12 December 2012

Student No: 3160-564-8

Project Title: Nurses' experience regarding in-patients who attempt or succeed  
In committing suicide in a general hospital in Gauteng, South Africa

Researcher: Mirriam Matandela

Degree: MA in Nursing Science

Code: MPCHS94

Supervisor: Dr MC Matlakala

Qualification: D Litt et Phil

Joint Supervisor: -

**DECISION OF COMMITTEE**

**Approved**

**Conditionally Approved**

**Prof L Roets**

**CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE**

**Prof MM Moleki**

**ACTING ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES**

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

## ANNEXURE B

### Approval of permission to conduct research study by Research and Ethics Committee, Gauteng Province Department of Health



**GAUTENG PROVINCE**  
HEALTH  
REPUBLIC OF SOUTH AFRICA

#### OUTCOME OF PROVINCIAL PROTOCOL REVIEW COMMITTEE (PPRC)

Researcher's Name (Principal investigator)	Miriam Matandela
Organization / Institution	University of South Africa
Research Title	Nurse's experience of patients who attempt or succeed in committing suicide in general hospital in Gauteng, South Africa
Protocol number	M080613
Date submitted	04/06/2013
Date reviewed	03/07/2013
Outcome	Approved
Date resubmitted	N/A
Date of second review	N/A
Final outcome	Approved
Date of final outcome	

#### Provincial Protocol Review Committee (PPRC) comments

- It is a pleasure to inform that the Gauteng Health Department has approved your research (Protocol M080613)

  
Dr. Bridget Ikafeng (PhD)

(PPRC): Chairperson

Date 13/08/2013

## ANNEXURE C

### Letter seeking consent from the Institution

The Department of Health  
Gauteng Province  
Johannesburg

I, Ms M Matandela, would like to request permission to collect data on the research topic: **NURSES' EXPERIENCES REGARDING IN-PATIENTS WHO ATTEMPT OR SUCCEED IN COMMITTING SUICIDE IN A GENERAL HOSPITAL IN GAUTENG, SOUTH AFRICA**. Data will be collected from nurses who provided care to patients who committed suicide whilst in hospital.

The study will contribute to the understanding of the life-world of nurses who work in a high risk environment for suicide. The research findings could be used by the nursing managers to develop guidelines to support the nurses who are exposed to these suicidal patients. It is envisaged that this would ultimately lead to improved patient care. This study furthermore will contribute towards the knowledge base of the nursing profession by documenting the nurses' views on their working circumstances, their experiences in the workplace and the influence of such experiences on the therapeutic relationship with patients.

\_\_\_\_\_  
Researchers signature

\_\_\_\_\_  
Date

Contact number: \_\_\_\_\_

## ANNEXURE D

### PARTICIPANT CONSENT FORM FOR RESEARCH PARTICIPATION

RESEARCH TITLE: **NURSES' EXPERIENCES REGARDING IN-PATIENTS WHO ATTEMPT OR SUCCEED IN COMMITTING SUICIDE IN A GENERAL HOSPITAL IN GAUTENG, SOUTH AFRICA**

Name of researcher: Mirriam

Surname: Matandela

Address: 56 Beatrix Street

Oberholzer

2499

Cell no: 083 545 4118

I appreciate your willingness to partake in this research study. I will contact you to arrange time for the interview to take place.

- Your participation in this study is voluntary, you are not obliged to divulge information you would prefer to remain private and you may withdraw from the study at anytime
- The researcher will treat the information you provide as confidential. You will not be identified in any document, including the interview transcripts and the research report, by your surname, first name or by any other information. A code will be used in all your documents.
- Research findings will be made available to you should you request them
- Should you have any queries about the research, now or in future, you are welcome to contact the researcher at the above contact details.
- There will be no monetary reward for participating in this study
- I appreciate your willingness to be involved in this study

I understand the contents of this document and agree to participate in this research

\_\_\_\_\_  
Name and Surname of participant

\_\_\_\_\_  
Signature of participant

\_\_\_\_\_  
Date

## **ANNEXURE E**

### **Data collection tool**

- What comes to your mind when you think about the patient that you nursed for a medical condition and you were called and informed that the patient is lying on the basement of the hospital severely injured?
- Explain the feeling you had when you went to casualty department and found the patient lying helpless, intubated, not responding with low Glasgow Coma Scale.
- How did you deal with the patient's death?
- Understanding that suicide within the hospital is a serious adverse event, how did the management of this serious adverse by Nursing Management Team affect you?
- What kind of support did you expect from Nursing Management?
- How did you deal with publicity from media, family and colleagues?
- How did this incident affect your day to day performance?
- What do you think can be done to prevent such incidents from occurring again?
- What can be done to prevent such experiences?