LIVED EXPERIENCES OF GENERAL NURSES WORKING IN STANDERTON HOSPITAL MEDICAL WARDS DESIGNATED TO BE A 72-HOUR ASSESSMENT FOR PSYCHIATRIC PATIENTS

by

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MASTER OF ARTS

in the subject

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UNIVERSITY OF SOUTH AFRICA

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November 2013
DECLARATION

I declare that LIVED EXPERIENCES OF GENERAL NURSES WORKING IN STANDERTON HOSPITAL MEDICAL WARDS DESIGNATED TO BE A 72-HOUR ASSESSMENT FOR PSYCHIATRIC PATIENTS, is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

21 November 2013

SIGNATURE
(Nozipho Felicity Gule)
ABSTRACT

The purpose of the study was to explore and describe the lived experiences of general nurses working at Standerton hospital medical wards which also admit psychiatric patients. A qualitative, descriptive phenomenological approach was used for the study. The study population consisted of seven general nurses working in medical wards at Standerton hospital. Purposive sampling was used to select participants who met the inclusion criteria. Researcher used in-depth face to face interviews to collect data until data saturation was achieved. Tesch’s method of qualitative data analysis was utilised to identify themes. Three themes and five sub-themes emerged from the study: theme1: perceived danger due to aggression sub-themes stress for medical patients, stress for medical patients’ families and stress for nurses. Theme 2: lack of skills in dealing with psychiatric patients’ sub-theme use of restrains. Theme 3: self fulfilling prophecy sub-theme reported incidences. The study findings demonstrate the plight of general nurses who are not trained to work with psychiatric patients but continue to do so. Findings further accentuate what is already known about the labelling that goes with psychiatric patients and aggression as a resultant effect. Recommendations were made for future research, policy makers, nursing education and practice.

KEY WORDS

Experience; general nurse; medical wards; psychiatric patient.
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- A special thank you to my supervisor, Professor Gloria Thupayagale-Tshweneagae, for her guidance and support. She was the best supervisor I could ever ask for, may the good Lord bless her and her family abundantly.
DEDICATION

This study is dedicated to all the nurses who had to look after psychiatric patients even though there are not trained to do so.
# CHAPTER 1

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List of abbreviations

GN          General nurse
WHO         World Health Organization
List of annexures

Annexure A  Ethical clearance from Department of Health Studies Research and Ethics Committee, College of Human Sciences, University of South Africa (UNISA)

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Annexure C  Permission to conduct the study obtained from Mpumalanga Department of Health's Ethics Committee

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CHAPTER 1

INTRODUCTION AND ORIENTATION OF THE STUDY

1.1 INTRODUCTION

The study describes a qualitative enquiry into the lived experiences of general nurses without psychiatric training working with psychiatric patients. This chapter gives an overview of the research problem, statement of the problem, significance of the study, the purpose of the study and objectives. An overview of the methods used in the study will also be discussed in this chapter and definitions of key concepts used in this study. The chapter concludes with an overview of the chapters to follow.

1.2 BACKGROUND

The study hospital is a level one hospital in the Mpumalanga province designated to be a 72-hour assessment hospital for psychiatric patients. Standerton Hospital admits both medical and psychiatric patients. Psychiatric patients are supposed to be admitted for 72-hour assessment and observation. According to Mavundla and Uys (1997:37), in rural areas medical and surgical units are found to be admitting psychiatric emergencies in the case of relapsed patients. However, due to referral system problems within the province it takes more than a week for transfers to be instituted. This scenario leaves non-psychiatric nurses with the burden to look after psychiatric patients while they have minimal knowledge of what to do or not to do.

The delay in transfer of patients to appropriate level of care with psychiatric ward poses problems for patients and their families. The majority of nurses working in those medical wards are trained in general nursing not in psychiatric nursing. According to Mavundla, Poggenpoel and G’meiner (1999:35), general hospital nurses do not provide appropriate support themselves because they are not adequately trained to nurse mentally ill people.
Most of the patients with psychiatric illness that are brought into the hospital are usually aggressive and violent. This poses danger to other psychiatric patients, medical patients, family members and general nurses who are expected to nurse them.

1.2.1 Psychiatric nursing

Psychiatric nursing is a specialised area of the nursing profession and centres on meeting the mental health needs of the public it serves (Barker 2009:234; Humble & Cross 2010:130). Nurses trained in this field learn to work with psychological issues that may hinder normal functioning of this clients. Psychiatric nurses work under changing emotional and physical environments for patients, and are required to show passion, an accepting attitude and patience (Howard & Holmshaw 2010:863). All these aspects can only be demonstrated by a nurse who has been trained in psychiatric nursing.

1.2.2 Psychiatric patients

Psychiatric patients or mental healthcare users as appropriately labelled in South Africa are persons with a firm diagnosis of a mental health disorder (Fontaine & Fletcher 2004:463). The majority of psychiatric patients are unpredictable and often unstable (Howard & Holmshaw 2010:869). According to Yussof, Kuranga, Balogun, Ajiboye, Issa, Adegunloye and Parakoyi (2008:187), psychiatric patients are only sent to the hospital when the families can no longer manage them. The authors further report that at most times patients will be violent and taking them to hospital is a way of allowing those better trained to manage them. However, Bobier and Warwick (2005:602) further contend that psychiatric patients when sent to the hospital for care put the hospital staff at risk. It is, therefore, appropriate to assume that those not trained in the care of psychiatric patients will be at an even greater risk.

1.2.3 General nurses

According to Dierick-vanDaele, Metsemakers, Derckx, Spreenwenberg and Vrijhoef (2009:391), general nurses are those nurses that are trained to provide nursing care to a wide variety of clinical settings including hospitals and the community. Their training emphasises the importance of working with other professions and planning
individualised care in partnership with patients. They are trained to nurse children, adults and older persons with medical and surgical conditions.

Nursing as a discipline mirrors the differences among bodies of knowledge; and human knowledge is divided into disciplines (Blais, Hayes, Kozićer & Erb 2006:14). Therefore, nursing as a discipline is defined by nursing. It is within this premise that a general nurse’s role and responsibilities are limited to general care.

1.2.4 Aggression associated with psychiatric patients

Aggression is a demonstration of violence, which could be directed to self, others and objects and it are a common feature in wards where there are psychiatric patients (James, Isa & Oud 2011:130). However, mental healthcare users or psychiatric patients as globally known have always been associated with some form of aggression.

The aggressions with psychiatric patients are the result of the unpredictability of their conditions (Humble & Cross 2010:129). The unpredictability of psychiatric patients’ environment has many negative outcomes for those looking after them. Care givers can suffer from stress, job strain, burnout and lack of job satisfaction (Kilfedder, Power & Wells 2001:384; Rooney 2009:76). According to Jonker, Goossens, Steenhuis and Oud (2008:495), in their study where they explored the experiences of nurses caring for patient aggression, noted that aggressive patients usually receive very poor care from the nurses.

1.2.5 Research problem

A research problem is an area of concern where there is a gap in the knowledge base needed for a profession practice (Burns & Grove 2005:70). The majority of nurses working at the study hospital medical wards are not trained in psychiatric nursing. Psychiatric patients are admitted because of their violent and aggressive behaviour which poses a problem for general nurses and other patients in the ward. According to Lam (2002:90), aggression and violence are experienced by many professionals, but nurses are more frequently affected.
1.2.5.1 **Source of the research problem**

Motivation for this study emanated from the observations made by the researcher on the number of assaults and aggressive behaviour meted against general nurses who did not have a clue as to how to react when a patient behaves in an aggressive manner. The majority of psychiatric patients admitted at Standerton Hospital are admitted because of their aggressive and violent behaviour. Several incidences of assault and violent acts from psychiatric patients are recorded. It was recorded in the *Standerton Hospital Annual Report 2010 and 2011* that psychiatric patients burned down cubicles of the male ward in 2010 and in 2011. Records of the above mentioned incidences are kept by an occupational health nurse and can be made available on request.

1.2.5.2 **Background of the research problem**

The restructuring of the healthcare system in South Africa and particularly in Mpumalanga is riddled with problems. The main problem is the shortage of professional nurses trained as psychiatric nurses who could be deployed to different settings. In the study hospital, there are 10 professional nurses working in both female and male medical wards. There is only one operational manager and two professional nurses doing community service trained in psychiatric nursing. General nurses working in those wards are faced with the challenge of being expected to care for psychiatric patients while they are not empowered with knowledge and skills to do so.

Mavundla (2000:1570) states that: “In South Africa general hospitals most nurses are not psychiatric trained”. These nurses consider themselves to be inadequately equipped to nurse psychiatric patients effectively. Owing to their lack of knowledge about psychiatric illness they tend to speculate about the origins or cause of psychiatric illness in patients they encounter and at times they would even go further to conclude that the condition of a patient is due to dagga or pretence.

As a result of their speculations these are generally uncertain about the patient’s condition and at times they fail to comprehend the patient’s condition. This leads to these nurses’ inability to read warning signs of violence within their units”. Caring for good people are difficult enough, to care for people who are either aggressive or violent is even more difficult (Bimenyimana, Poggenpoel & Myburg 2009:4).
1.3 PURPOSE OF THE STUDY

The specific purpose of nursing research includes identification, description, exploration, explanation, prediction and control Polit and Beck (2012:74). The purpose of the current study is to explore and describe the lived experience of general nurses working at Standerton Hospital medical wards also admitting psychiatric patients.

1.4 OBJECTIVES

In order to meet the purpose of the study, the following objectives aim to:

- Explore and describe the experience of general nurses working at Standerton Hospital’s medical wards designated to be a 72-hour assessment facility for psychiatric patients.
- Describe recommendations which would facilitate support for general nurses working in medical wards with psychiatric patients.

1.5 RESEARCH QUESTION

The study intends to answer the following research questions:

- What are the lived experiences of general nurses working in medical wards also admitting psychiatric patients who display aggressive and violent behaviour?
- What are the appropriate recommendations that could facilitate support for general nurses working with psychiatric patients?

1.6 SIGNIFICANCE OF THE STUDY

Caring constitute the primary focus of the nurse in a clinical setting. There is also an assumption among communities that “a nurse” would be able to render care to all patients regardless of their condition. However, this assumption is not true in situations where nurses are not trained.
Gaining insight into the experiences of nurses who are not trained in psychiatric nursing is useful. General Nurses find it difficult to nurse a psychiatric patient because they don’t have sufficient communication and interviewing skills needed for psychiatric patients. Any level of uneasiness has the likelihood of translating into negative attitudes and behaviours towards patients (Harms 2010:17).

The researcher envisages that the study’s recommendations will have an influence on policy, education, practice and research. Policy makers would carry out a proper situational analysis for planning before a hospital is designated to be a 72-hour assessment facility. Such planning may include ensuring that there are enough psychiatric nurses who have the knowledge and skills for nursing psychiatric patients. All nurses would be given training on psychiatric skills because psychiatric patients also visit the healthcare system for physical ailments and nurses need to be prepared for such eventualities.

Ongoing in-service training may also be made mandatory for nurses to update and improve their skills. Nursing schools that train general nurses will also be advised to have introductory modules on psychiatric nursing. The knowledge and skills gained from the above mentioned recommendations will allay anxiety and fear from general nurses and ensure that they can render quality care for psychiatric patients.

This study will also set a foundation for future research on the experiences of nurses in different settings of care where there is no formal training.

1.7 DEFINITIONS OF KEY CONCEPTS

1.7.1 Experience

This is defined by Benner (1994:xi) as being engaged in practices as a being who acts in and on the world. A lived experience is understood to be the way in which people encounter situations in relation to their interests, purposes, personal concerns and background understanding (Benner 1994:186). Soanes and Stevenson (2006:18) further defines experience as an accumulation of knowledge or skills that result from direct participation in events or activities known only to the person who has lived
through it and often makes an impression on the person. For the purpose of this study, experience will share the same meaning as Soans and Stevenson (2006:18).

1.7.2 General nurse

For the purpose of this study, a general nurse is a person who has graduated with a diploma in general nursing and who is registered with a statutory body as a general nurse and has not trained in psychiatric nursing.

1.7.3 Psychiatric patient

A psychiatric patient refers to a person with a behavioural or psychological syndrome or patterns that occur and is associated with distress or disability (Kneisl & Trigoboff 2009:6). Psychiatric patient in this study will mean any person – male or female – admitted for a 72-hour assessment for mental illness.

1.8 RESEARCH DESIGN

Research design is a blueprint for conducting the study that maximises control over factors that could interfere with the validity of the findings (Burns & Grove 2005:211). This will be a qualitative descriptive study whereby the lived experience of general nurses will be explored and described within an interpretive phenomenological approach. An interpretive approach allows for a specific way to interpret the captured lived experiences (Svenaeus 2000:126).

1.8.1 Qualitative research

A qualitative research design will be used for the study because it will enable the researcher to explore and describe the lived experience of general nurses in an in-depth and holistic manner. According to Bless and Higson-Smith (2000:109), an exploratory research is conducted to gain insight into a situation or phenomenon. The exploratory design will enable the researcher to gain insight and understanding of the lived experience of a general nurse. The study will also be descriptive with the aim of describing a particular phenomenon (Higson-Smith 2000:154). In descriptive design, the
lived experience of general nurses will be explored and described in a more structured manner.

1.8.2 Descriptive design

According to Polit and Beck (2010:236), the purpose of a descriptive design is to observe and describe aspects of a situation. Descriptive design is further explained as an overall plan of the study and it includes all the processes of data collection analysis and interpretation of the results (Holloway & Wheeler 2010:338).

1.9 RESEARCH METHOD

Polit and Beck (2010:567) defines research methods as techniques used to structure a study and to gather and analyse information in a systematic way. It is the processes, tools and procedures that are used in data collection, analysis and interpretation (Babbie & Mouton 2001:75).

In-depth face-to-face, audio-taped individual semi-structured interviews were used to collect data from seven participants who met the eligibility criteria. Purposive sampling was done to select seven general nurses working with psychiatric patients. Tesch’s method of data analysis was used (Creswell 2009:185).

1.10 MEASURES TO ENSURE TRUSTWORTHINESS

Lincoln and Guba (1985:300) framework suggested four criteria for developing the trustworthiness of qualitative research. The four criteria are credibility, dependability, transferability and confirmability. The criteria as applied in this study are discussed in detail in Chapter 3.

1.11 ETHICAL CONSIDERATIONS

Polit and Beck (2010:553) define 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. Qualitative research is not without ethical issues as the researcher by engaging in the study also invades the participants’ natural
environment (Streubert & Carpenter 2011:61). Ethical principles of beneficence, autonomy and justice must be the cornerstone in every research (Streubert & Carpenter 2011:61).

In this study, ethical principles that were applied are autonomy, beneficence, informed consent and justice. Scientific integrity was also adhered to.

1.11.1 Autonomy

Participants’ right to self-determination was respected. The participants were given detailed information about the research to enable them to make informed decision when signing the consent forms. A written statement explaining the purpose of the study and procedure for data collection was developed and given to them. This allowed for consistency of information. It was emphasised to the participants that their participation in the study was voluntary and that they would not be penalised for not participating. The right to withdraw anytime during the process of interviewing was repeated to allow participants the freedom of choice. Participants were also allowed to ask any questions pertaining to the researcher and the study.

1.11.2 Beneficence

Polit and Beck (2008:170) regard the principle of beneficence as the researcher’s responsibility to ensure that participants in the study are not exposed to any harm directly or indirectly. Streubert and Carpenter (2011:61) further state that the principle of beneficence is grounded in the premise that any participant has the right to be protected from emotional and physical harm.

In this study, the researcher was careful that the participants were free from any harm. This was achieved by interviewing participants alone, at a place known only by the researcher and the participants. The researcher further emphasised to the participants that if they felt uncomfortable at any time during the course of the interviews, they could alert the researcher who had arranged for counselling with the hospital counsellor at no charge to the participants.
1.11.3 Justice

The right to fair treatment is based on the ethical principle of justice (Burns & Grove 2011:107). This principle assumes that each and every participant should be treated fairly and with dignity. Participants were chosen for the purpose of the objectives stated in the study. All the participants who met the criteria were invited to participate in the study, and only information pertaining to the study was solicited from them.

The information entrusted to the researcher by the participants will not be divulged. The researcher kept all the information obtained from the participants in her private save.

1.11.4 Confidentiality

Confidentiality is a pledge taken by the researcher not to divulge any information provided by the participants and that information given should not be traceable to the participants (Streubert & Carpenter 2011:61). This principle is entwined in the principle of beneficence, because doing no harm applies to providing confidentiality and keeping informants anonymous (Streubert & Carpenter 2011:61).

Confidentiality and anonymity were prioritised throughout the study. The interviews were conducted individually in a private place known only by the researcher and the participants. The names of participants were not used and codes were used known only by the researcher. This was in line with Johnson and Christensen (2012:116), who stated that confidentiality means not revealing the identity of the participant to anyone other than the researcher.

1.11.5 Informed consent

Informed consent is the agreement made by participants that they will participate in the study. This agreement means that the participants were not coerced into taking part in the study and it demonstrates that the participants understood what the research was about (Streubert & Carpenter 2011:61). Informed consent is further defined by Johnson and Christensen (2012:107) as agreeing to participate in the study after being informed of the purpose, procedure, risks, benefit and limits of confidentiality.
In this study, the participants were given an information leaflet, which contained the title of study, purpose, procedures for data collection and analysis, risks and benefits of the study. This information was repeated again just before data collection.

The participants signed a written consent form which was witnessed by the researcher. The signing of the consent form served as a verification that the participants agreed to participate and understood what the research was about.

1.11.6 Protecting the rights of the institution

Ethical clearance was obtained from the Department of Health Studies Research and Ethics Committee, College of Human Sciences, University of South Africa (UNISA) before commencement of the study (Annexure A). Permission to conduct the study was requested and obtained from the Mpumalanga Department of Health’s Ethics Committee (Annexures B and C). Permission was further requested and obtained from the study hospital management (Annexures D and E).

1.11.7 Maintaining an ethical researcher-participant relationship

The researcher works in the study hospital. It was, therefore, imperative not to confuse the role of a “researcher” with that of “employee”. Participants invited to take part in the study were general nurses working with psychiatric patients and who have worked with psychiatric patients for more than one year were. This criterion was strictly adhered to.

1.12 SCIENTIFIC INTEGRITY

Research was conducted professionally and there was no falsification of information. Data was not manipulated and the researcher’s views were always kept in check so as not to interfere with the findings. The researcher acknowledged all references used in the study and the report are a true reflection of the study findings.
1.13 STRUCTURE OF THE THESIS

Chapter 1: has introduced the dissertation, including the background to the study, the statement of the research problem and a layout of all the chapters contained in the study.

Chapter 2: presents the literature relevant to the lived experiences of general nurses working with psychiatric patients. The concepts of mental health, mental illness and aggression are also given to situate some of the conditions experienced by general nurses working with psychiatric patients.

Chapter 3: will introduce qualitative research and explain the rationale for choosing the used method. The philosophical underpinnings of why an interpretive phenomenology was chosen will also be discussed. The data collection and data analysis processes will be discussed in detail.

Chapter 4: gives the findings of the study. Demographic details of the participants with their real names replaced by pseudonyms will be presented. The themes that emerged from the study are also presented.

Chapter 5: situates the findings of this study with relevant literature. The chapter also expounds the data obtained from the interviews on the general nurses’ lived experiences. The findings are also discussed with reference to nursing psychiatric patients.

Chapter 6: presents general conclusions and limitations of the study. It also gives recommendations for practice, policy and future research in this area. The unique contributions of this particular study are also given.

1.14 CONCLUSIONS

This chapter has provided a brief overview of the study. It has also introduced some concepts relevant to psychiatry, psychiatric patients and the structure of the study hospital. It ends with the overview of other chapters in the study.
CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Chapter 2 will discuss the review of the literature pertaining to the study using the thematic method. The search for pertinent data began with the identification of terms within the study topic of lived experiences of general nurses working with psychiatric patients. Computer searches of PubMed, Ebasco and Medline were used to search and retrieve research and non-research articles. Books and monograms were also used. The themes that emerged from the search were nurses’ perceptions, attitudes and the aggression of psychiatric patients. The literature will also focus on mental illness or psychiatric illness as a concept.

2.3 PSYCHIATRIC ILLNESS

Fontaine and Fletcher (2004:468) define psychiatric illness as any pattern or behavioural symptoms that causes an individual significant stress, impairs their ability to function in life, and/or significantly increases their risk of death, pain, or loss of freedom. In addition, the symptoms must be more than an expected response to a particular event such as normal grief.

The South African Mental Health Act (Act 17 of 2002) refers to psychiatric illness or mental illness as a “positive diagnosis of a mental health related illness in terms of accepted diagnostic criteria made by a mental healthcare practitioner authorised to make such diagnosis (page 6). In most countries, the definition of psychiatric illness must meet the diagnostic criteria stipulated in DSB-III, DSM-IV and DSM-V.

The definitions of mental illness or disorder are at times questioned. Mental illness remains blurred even today and the only feature acknowledged is that there is prolonged instability (emotional and psychological) among persons deemed to have mental illness (Stein, Phillips, Bolton, Fulford, Sadler & Kendler 2010:1759).
2.4 GENERAL NURSES’ EXPERIENCE WITH NURSING PSYCHIATRIC PATIENTS

There are many studies that have been done about the experiences of non-psychiatric trained nurses in caring for psychiatric patients. Studies on this same topic have been done in Southern Africa and South Africa from the last two decades (Basheer 1998:23; Mavundla 2000:1573; Seloilwe 2006:263). These studies alluded to the fact that attitudes (positive or negative) have an impact in how general nurses experience caring for the psychiatric patients.

Most of what is alluded to is attitudes emanating from the nurses’ personal meanings about psychiatric patients. Kindy, Petersen and Parkhurst (2005:169) reported that the personal meanings of nurses working in assaultive environments and how they perceive the consequences for their professional lives are missing from the literature. This is supported by Seloilwe and Thupayagale-Tshweneagae (2007:175) who wrote that registered nurses are reluctant to work with psychiatric patients when they are not qualified or trained to do so. In South Africa, Mavundla (2000:1573) also alluded to the fact that general nurses feel inadequate to care for patients with mental illness.

There are many studies that have reported that nursing psychiatric patients need training, skill and knowledge. These studies have been reported since the past three decades and the findings are still the same. Bates, Smith and Brunero (2006:1) stated that the nursing care for patients suffering from psychiatric conditions require knowledge and understanding of their various behavioural patterns and knowledge on how to cope.

Furthermore, specific techniques of all types of problematic behaviours need to be learned by these nurses in order to provide skilled therapeutic care to these patients. This indicates that psychiatric nursing is a highly specialised field in its own right, which requires specific specialised training. This is very important as the nursing care of psychiatric patients usually differs considerably from nursing patients in general wards, where the patients are sometimes considered easier to work, and are also considered to show faster improvement than psychiatric patients.
Willetts and Leff (2003:237) have found that general nurses report poor knowledge and skills, lack of assistance and the need for ongoing support and education to provide effective care. Kerrison and Chapman (2007:49) reported that non-mental health trained nurses are ill-equipped in their psychiatric knowledge, assessment and communication skills to provide best possible care to patients with complex mental health issues.

Sharrock and Happell (2006:11) stated in their study that there is a growing body of evidence to suggest that nurses working in general hospital settings do not generally consider themselves adequately prepared, skilled or experienced to care for patients with mental health problems. She added that in fact the issue is not restricted to knowledge skills of general nurse but also to scope of practice. Gillette, Bucknell and Meegan 1996:63) in their study of general emergency nurses found that they questioned their role in the care of patients with mental health problems and did not see it as part of their real work.

It is noted in literature that a well-educated nursing staff is fundamental to the delivery of safe and effective care to patients (Charleston & Happel 2005:304; Mullen & Murray 2002:63). Many studies have alluded to training of general nurses working with psychiatric patients that they should be equipped with the right knowledge and skills if required to look after psychiatric patients (Happell 2008:326).

2.5 THE ATTITUDES OF GENERAL NURSES TOWARDS PSYCHIATRIC PATIENTS

Lethoba, Netserwa and Rankhumise (2006:6) stated that people’s attitudes are influenced by a variety of factors such as behaviour, experience, knowledge of a problem and general belief. In early studies conducted by Wilkinson (1982:239), he proposed that the principle elements underlying general nurses’ negative attitudes towards mental illness are those of fear and distrust. The proposition is based on his research findings which indicated that general nursing students often regarded psychiatric patients as more frightening less likely to cooperate with treatment, more likely to be violent and dangerous and more likely to need more strict control in hospital (Mokgabisi 2007:15). This assertion is supported by MacNeela, Scott, Treacy, Hyde and O'Mahony (2012:201) when they reported that psychiatric patients are liable to
stereotyping by healthcare providers and concluded with recommendations for general nurses to be trained in psychiatric care.

Aromaa (2011:2) reported that nurses in medical wards are often under stress when attending to patients with dual diagnosis of physical and mental illness as they feel that such patients should be admitted in psychiatric wards. General nurses in this study expressed their feelings that they will not be held responsible if patients jump out of windows and die. Elements of fear and nervousness in nurses’ attitudes were identified. Studies have found a great reluctance on the part of general nurses to care for mentally ill patients.

Mavundla and Uys (1997:3-4) found out that 90% of nurses in general hospitals in Durban harbour had negative attitudes and 10% had positive attitudes towards nursing mentally ill patients. Dean and Meocevic (2006:44) Hamdan-Mansour and Wardam (2009:705-711) indicated that attitudes influence behaviour. Attitudes towards people with mental illness are frequently negative, stigmatising, uninformed and fearful. Healthcare professionals share these negative attitudes to a certain extent therefore compromising their ability to deliver competent and compassionate care. Emrich, Thompson and Moore (2003:20) stated that healthcare professionals are not immune to social prejudices and share public’s irrational fears and expectations of unpredictability attributed to mentally ill people.

Reed and Fitzgerald (2005:254) reported that 50% of participants expressed clear dislike of caring for people with mental health problems and stated the factors that influenced these negative attitudes are high perception of danger due to unsafe environment, lack of time, support and education and stigma attached to mental illness. The negative attitudes of nurses in the study led to avoidance that discriminated against people with mental illnesses. Dean and Meocevic (2006:43) also pointed out that avoidance compromises nursing care by reducing the amount and quality of care the patient receives. The nature of experiences whether positive or negative has important influence on the nurses’ attitudes. In the same study it was found that repeated positive experiences could alter attitudes making nurses feel comfortable about care provision and quality.
Brinn (2000:33) reported that the experienced nurses were more positive about caring for people with mental health problems relative to the extent of their experience. In their study’s findings, MacNeela et al (2012:207) suggested a stereotyped rather than specialised understanding. Attitudes were dominated by an interpretive framework of risk for harm and perception of vulnerability. Unpredictability, danger and need for order were prioritised over relationship building. Nurses in medical and surgical wards needed improvement in their preparedness in dealing with mentally ill people. This assertion is supported in literature (Clark, Parker & Gould 2005:206; Sharrock & Happell 2006:12; Ross & Goldner 2009:559).

Clark et al (2005:208) did a survey of 163 general nurses working with psychiatric patients, who were being treated medically in a rural hospital, 70% of the participant felt ill-prepared to work with psychiatric patients. This study was supported by Ross and Goldner (2009:559). Their study found that nurses’ negative attitudes towards psychiatric patients were borne out of the stigma and discrimination associated with mental illness. In yet another study done on attitudes of nurses towards nursing psychiatric patients, Reed and Fitzgerald (2005:250), reported that there are three factors that influence the nurses’ negative attitudes as “unavailability of specialised mental health services; the assumed aggressiveness of psychiatric patients and a lack of knowledge in nursing them”. The majority of the nurses in this particular study reported having experienced aggressiveness either directly or indirectly from the psychiatric patients. Fear of aggression leads to poor nursing care for patients.

Addison and Thorpe (2004:232) have also found that there is a strong correlation between knowledge of mental illness and the negative or positive attitudes displayed. For instance, nurses with the knowledge and skill tend to accept the volatile nature of psychiatric patients, whereas those without tend to assume the worst and distance themselves from their care.

2.6 THE PERCEPTION ABOUT PSYCHIATRIC PATIENT

Mavundla (2000:1574) findings on perception of patients was that possession or a lack of knowledge and skills to nurse mentally ill patients in general hospital setting determined nurse’s perception of mentally ill patient. General nurses felt that psychiatric trained nurses would have positive perceptions as compared to general
nurses who would have negative perceptions because of knowledge deficit on how to deal with mentally ill patient.

General nurses viewed the presence of psychiatric patient as a hindrance that was going to interfere with their duties. They stated that mentally ill patients were wandering outside the ward and might get lost or run away. Issues of noise causing disturbance on the quiet environment of the hospital were also stated. Violent behaviour and aggression towards nurses and other patients were also revealed. General nurses also stated that mentally ill patients displayed bizarre behaviour and of which they are not familiar with, such as walking around naked (Mavundla 2000:1576). The negative perception of mentally ill patients in general hospital was also revealed in the earlier study conducted by Mavundla and Uys (1997:4) in which nurses responded negatively to items that measured stereotypes upheld by the public about mentally ill patients.

Ashmore, Jones, Jackson and Smoyak (2006:562) stated that past experiences with mentally ill patients can ruin or strengthen the perception of these patients to nurses. Negative experience heavily influences nurses’ perception. Nurses who had negative experience with mentally ill patients experienced an increase in level of anxiety, increased feeling of unhappiness and anger. Ashmore et al (2006) stated that a nurse having negative experiences with mentally ill patient will be reluctant to interact with them and will avoid them.

The study done by James et al (2011:132) in Nigeria found that nurses in Nigeria were more inclined to perceiving aggression from mentally ill patients as offensive, destructive and intrusive. Nurses’ view of aggression had negative impact on patient-care because patients who exhibit acts of aggression are more likely to receive poor care. Physical restraints and sedation using psychopharmacological agents were the common methods used to manage aggression.

2.7 THE CHALLENGING NATURE OF PSYCHIATRIC CARE

Psychiatric patients require unique and specific care (Zarea, Nikbakht-Nasrabadi, Abbaszadeh & Mohammadpour 2013:124). Health care providers who work with psychiatric patients need specific training to enable them to work with impeding challenges (Barker 2009:234). An environment where there are psychiatric patients is
described as volatile and insecure (Howard & Holmshaw 2010:863). It is through this volatility that the environment then brings different anxieties and challenges (Rooney 2009:78).

According to Zarea et al (2013:129), the greatest challenge faced by healthcare workers, especially nurses working with psychiatric patients, is their preoccupation with safety and security for themselves (psychiatric patients and their families). It is within this premise that caring for psychiatric patients need knowledge, ample training and skill for dealing with patients. The unique needs of psychiatric patients are such that without training one would fail (Gournay & Bowers 2000:124).

### 2.8 CONCLUSION

Two studies were found in South Africa which explored topics related to general nurses working with psychiatric patients. The two studies found were both quantitative. Most of the studies reviewed were from Europe. All studies reported that it was essential for nurses working with psychiatric patients to be trained. All the studies reviewed alluded to aggression – perceived or real – among psychiatric patients as the main factor for enacting negative attitudes towards psychiatric patients. The next chapter will discuss the research methods used in the study.
CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter describes the research methodology used in this study. A qualitative phenomenological strategy was used in the drive to better understand the lived experiences of general nurses working with psychiatric patients. Research methodology focuses on the process, tool and the procedure utilised during the research process (Babbie & Mouton 2001:75). The research process included one-on-one and face-to-face interviews with seven general nurses working with psychiatric patients. The discussion in this chapter will include:

- research design
- research method
- population
- sample and sampling technique
- ethical rigor
- data collection
- data analysis

This chapter concludes with strategies for achieving trustworthiness as well as a summary.

3.2 RESEARCH DESIGN

The research design is a blueprint for conducting the study that maximises control over factors that could interfere with the validity of the findings (Burns & Grove 2009:218). It guides the researcher in planning and implementing the study in a way that is most likely to achieve the intended goals. The study will be a qualitative descriptive study whereby the lived experience of a general nurse will be explored and described within
interpretive phenomenological approach. An interpretive approach allows for a specific way to interpret the captured lived experiences (Svenaeus 2000:126).

### 3.2.1 Qualitative research

Burns and Grove (2009:22) define qualitative research as an approach which the research takes as its departure point. A qualitative research design was used for the study because it enabled the researcher to explore and describe the lived experiences of general nurses in an in-depth and holistic manner. According to Burns and Grove (2009:248), qualitative research is conducted to gain insight and to discover meaning about a particular experience, situations, cultural element or historical event.

Qualitative designs are inductive in nature and allow the researcher to use a more flexible design and its main focus is on the holistic approach (Polit & Beck 2010:16).

#### 3.2.1.1 Exploratory design

According to Bless and Higson-Smith (2000:109), an exploratory research is conducted to gain insight into a situation or phenomenon. Exploratory design enabled the researcher to gain insight and understanding of the experiences of general nurses. The study will also aim to describing a particular phenomenon Higson-Smith (2000:54). In the descriptive design, the experiences of general nurses were explored and described in a more structured manner.

### 3.3 PHENOMENOLOGY

Phenomenology is a philosophy as well as a methodological approach. This approach is attributed to a German philosopher Edmund Husserl (1859-1938) (Vivilaki & Johnson 2008:84). Other scholars came after him and explored his theory further. Such scholars included Martin Heidegger (1889-1976); Gabriel Marcel (1889-1973); Maurice Merleau-Ponty (1908-1961) and Jean-Paul Sartre (1905-1980). All these scholars studied human experiences. Phenomenology focuses on the lived experiences of participant. As a philosophy, phenomenology has many schools of thoughts. A descriptive phenomenology was the focus in this study.
A phenomenological design provides a picture of a situation as it naturally happens (Polit & Beck 2012:494). According to Streubert and Carpenter (2011:81), a phenomenological design focuses on individuals’ perception of lived experiences while emphasising the complexity of those experiences. Phenomenology utilises special descriptive strategies, such as intuiting, bracketing, analysis and description.

Intuiting refers to the process of thinking through the data in order to achieve an accurate interpretation of what is described (Streubert & Carpenter 2011:81]. In intuiting, the researcher becomes absorbed by the phenomenon under study without any influences from what the researcher believes in. The result of intuition is that the researcher will have a deep understanding of the phenomenon being investigated (Streubert & Carpenter 2011:81).

Bracketing refers to the process by which researchers have to identify their own beliefs and assumptions about the phenomenon under study (Polit & Beck 2012:495). It is essential for researchers to identify their own assumptions and presumptions so that they do not interfere with the information given by participants. Bracketing requires researchers to remain neutral throughout the study and to suspend their beliefs and assumptions.

In this study the researcher suspended all her beliefs and assumptions about being a general nurse working with psychiatric patients. This was done to allow the participants’ “truth” to come out and to improve the trustworthiness of the results (Streubert & Carpenter 2011:22).

Analysis involves the identification of the essence of the phenomenon under investigation based on the data obtained and how it was presented (Woods & Catanzaro 1998:140). During the analysis process, the researcher listens to the participants’ descriptions and compares and contrasts the description of the phenomenon to identify recurring themes. Description is the last step in the phenomenological approach. It aims to communicate and describe in detail the critical elements of the phenomenon (Woods & Catanzaro 1998:140).
3.4 RESEARCH METHOD

According to Polit and Beck (2008:15), research methods are techniques researchers use to structure a study and to gather and analyse information relevant to the research question. In-depth interviews were used by the researcher.

3.4.1 Context

The study was carried out in Standerton, a large commercial and agricultural town lying on the banks of the Vaal River in Mpumalanga, South Africa. The exact location of the study was the Standerton Hospital medical wards. The hospital caters for two municipalities, Lekwa and Dipaliseng. The total population for both municipalities is 146 811. The hospital has 195 usable beds. The number of psychiatric patients admitted in both medical wards ranges from two to seven per month.

Figure 3.1 The main entrance of Standerton Hospital which leads directly into casualty department
(Adopted from the Standerton Hospital Profile 2003)
3.4.2 Population

Brink (2006:123) defines population as all elements (individuals, objects, events or substances) that meet the sample criteria for inclusion in a study (Polit & Beck 2012:273) describes population as the totality of all subjects that conform to a set of specification. The population of the current study consisted of all general nurses working at Standerton Hospital in both medical wards designated for 72-hour observations of psychiatric patients. General nurses were also involved in rendering care for psychiatric patients in those medical wards. The participants met the inclusion criteria set out in this study.

3.4.2.1 Inclusion criteria

The inclusion criteria specify the characteristics of the population that the researcher wants (Polit & Beck 2012:274). In this study, the researcher selected only those participants who specifically met the criteria. Participants had to be:

- General nurses who do not have psychiatric training but are caring for psychiatric patients.
- General nurses without psychiatric training and had been working with psychiatric patients in medical wards for one year or more.
- General nurses with the above characteristics and also willing to participate in the study.

3.4.3 Sample and sampling technique

Polit and Beck (2008:339) describe sampling as the process of selecting a subset of a population in a way that represents the entire population in order to obtain information regarding a phenomenon. For this study, a purposive sampling technique was used to recruit research participants (Creswell 2007:348). Purposive sampling is a technique in which the investigator chooses the participants on a judgement of the extent to which the potential participants meet the selection criteria (Welman & Kruger 2000:63). Purposeful sampling allows investigators to choose a case because it illustrates some feature or process in which the investigator is interested (Silverman 2000:104). In this study, the researcher wanted to recruit general nurses who care for psychiatric patients.
while not trained in psychiatric nursing. These nurses gave in-depth information about their lived experiences while working there.

3.4.3.1 Sample size

A sample size for a qualitative is the one that appropriately answers the research question (World Health Organization [WHO] 2013:2). This is supported by Morse and Field (1996:2) who suggest that a sample of 10 or less is appropriate for phenomenological research because the goal is to achieve understanding of the specific lived experience rather than to produce findings that can be generalised. WHO (2013:2) further reported that the validity and insights generated from qualitative studies and the analytical qualities of the researcher are more important than the sample size. A sample of seven general nurses was available for the study because of the allocation of professional nurses in both medical wards. Saturation of data occurs when additional sampling provides no new information but only the redundancy of previously collected data (Burns & Grove 2005:358). Saturation of data occurred after the fourth participant but researcher continued to interview all seven participants.

3.4.4 Ethical consideration/rigor

The interviews for this study were conducted at Standerton hospital in Mpumalanga. Permission or approval to conduct the study was obtained from the Standerton Hospital medical manager, chief executive officer, chief director hospital services (Annexure E).

Researcher also obtained permission to conduct the study from the Mpumalanga Provincial Research and Ethics Committee (Annexure C).

Participants gave permission by signing informed consent forms, which stated their rights to participate voluntarily on the study and that they could withdraw from the study at any time. Consent forms emphasised the participant’s right to confidentiality and to remain anonymous (Annexure F).
3.4.5 Data collection

Data collection is a precise, systematic gathering of information relevant to the research purpose or specific objectives, questions or hypothesis of a study (Burns & Grove 2005:42). The data collection method used for the study was unstructured in-depth interviews. Unstructured interviews are used primarily in descriptive and qualitative studies. According to market research, in-depth interviews provide more quality data for less money than focus groups (Palmerino 1999:33).

3.4.5.1 In-depth interviews

Interviews are an inter-active process in which ideas, thoughts, belief emotions and values are brought to the knowledge of others and shared (Eide & Kahn 2008:200). The most important issues in people’s lives only become known to others through interviews (Kvale 1996:1). Qualitative interviews attempts to understand a phenomenon through the participant’s perspective (Kvale 1996:1). Interviews are a shared journey between the participant and the interviewee. The researcher was, therefore, the primary data collection instrument.

According to Guion, Diehl and McDonald (2012:1), in-depth interviews are useful for open unstructured questions because they allow flexibility. The authors further reported that interviews elicit depth of information from relatively few people.

3.4.5.2 Unstructured questions

Unstructured interviews in qualitative research involve asking open-ended questions of research participants in order to discover their experiences in a specific phenomenon under study (Firmin 2008:1). Firmin further reported that unstructured interviews are useful where the depth rather the breadth is important. Unstructured interviews were conducted with general nurses who met the inclusion criteria.

3.4.6 Phases of data collection

There were three phases of data collection. The initial phase was the preparatory phase, followed by the pilot phase and the last phase was the interview phase.
3.4.6.1 Preparatory phase

The researcher had a brief meeting with all the participants prior to the actual data collection. The meeting was aimed at briefing them about the research; thanking them for agreeing to participate in the study; and to allay anxiety.

3.4.6.2 Pilot testing

A pilot study is a small-scale methodological test conducted to prepare for the main study (Holloway & Wheeler 2010:341). The pilot study provides the researchers with an opportunity to make adjustments and revisions in the study (Polit & Beck 2008:563). Pilot testing occurred a week before the main study. The grand tour question for this study was: “Tell me your experiences of being a general nurse working with psychiatric patients”. This open-ended question was followed by probes. The pilot study involved two general nurses working with psychiatric patients who were not part of the actual study. The participants understood the question and no adjustments were necessary.

3.4.6.3 The interview phase

Interviews were held in a room arranged for the study. It was a quiet place and privacy was always provided. The room was well ventilated and the researcher ensured that participants were comfortable during interviews. The researcher had one-to-one interview with each participant. Before starting with the interviews, researcher gave participants consent forms to read, ask questions, understand and sign when satisfied with the content. Permission to use a voice recorder during interviews was also asked for from participants. The researcher also explained the reasons for using it.

The researcher started by obtaining demographic data of participants like name and surname, age, nursing qualifications and years of experience. She reassured participants about confidentiality and that they would remain anonymous. The researcher started each interview with this statement of enquiry: “Tell me your experiences of being a general nurse working with psychiatric patients”.

Further discussion and other questions emanated from this question. The researcher used her interviewing skills as a psychiatric nurse to encourage participants to talk
about their lived experiences in nursing psychiatric patients. The participants were encouraged to elaborate on their responses; this allowed flexibility in gathering information from them (Burns & Grove 2009:513). All participants were given opportunities to review, clarify and correct any point within their transcript.

The voice recorder and consent forms were kept safe in the researcher’s locker which was locked at all times.

3.5 MEASURES TO ENSURE TRUSTWORTHINESS

Lincoln and Guba (1985:300) describe trustworthiness as the truth value, applicability, consistency and neutrality of an inquiry. It is essential for any study to have trustworthiness established so as to be considered methodologically appropriate and worthy of attention.

Trustworthiness is achieved through strategies that demonstrate credibility, transferability, dependability and confirmability (Lincoln & Guba 1985:302).

3.5.1 Credibility

Credibility refers to confidence in the truth of the data and interpretations of them Lincoln and Guba (1985:300). Credibility is shown when the research participants identify the research findings as their own experiences (Streubert & Carpenter 2011:38). To ensure credibility, the researcher must make sure that the participants’ experiences are described accurately (Holloway & Wheeler 2005:8). In this study, credibility was ensured through prolonged and varied engagement in the field, reflexivity, peer debriefing and member checking.

3.5.1.1 Prolonged and varied engagement in the field

Prolonged engagement refers to the investment of time in the study site in order for the researcher to become familiar with the participants’ culture and to build trust (Lincoln & Guba 1985:302). Spending time in the research site enables the researcher to detect any distortions from self or others in the participants’ sphere.
Prolonged engagement was one of the strategies used by the researcher to increase the study’s credibility. The researcher works in the same study hospital as participants and was able to inform the participants about the study six weeks before data collection. This allowed the participants and the researcher to establish trust and to agree upon their mutual goals without coercion.

The researcher has been a psychiatric mental health nurse for more than five years and was aware of the mental health issues that might arise during the encounter with the participants. The researcher speaks Zulu – a first language for the majority of the participants. Only one participant spoke Afrikaans, and that was not a problem.

3.5.1.2 Reflexivity

Reflexivity is a process in which an investigator seeks to understand how her personal feelings and experiences may influence the study, and then strives to integrate this understanding into the study (Burns & Grove 2009:380). Reflexivity requires the researcher’s self-awareness and considers the possible influences of the researcher’s personal characteristics on the study. According to Lincoln and Guba (1985:130), reflexivity is incorporated into the research method in order to offset researcher bias.

In this study, the researcher frequently reflected on what she had recorded in her field notes during the interviews with participants to ensure that the analysed data adequately represented the contributions of participants (Lincoln & Guba 1985:304). Furthermore, the researcher shared and discussed with her supervisor and other colleagues the personal feelings she had experienced during the data gathering when the participants related some of their experiences. During those occasions, she was especially cautious not to impose her own ideas on the research participants.

3.5.1.3 Member checking

Member checking is the constant verification of the preciseness of the information obtained from the participants (Polit & Beck 2008:545). Doyle (2007:889) noted that member checking is a quality control process by which the researcher seeks to improve the accuracy and validity of what has been recorded during the research interview. In this study, the researcher continuously asked the participants if what is recorded is the
true reflection of what she has captured (Harper & Cole 2012:511). The researcher also discussed the themes that emanated from the study with the participants to get their confirmation.

### 3.5.1.4 Peer debriefing

Lincoln and Guba (1985:300) reported that peer debriefing supports the credibility of the data in qualitative research and provides a means toward the establishment of the overall trustworthiness of the findings. In this study, the researcher had arranged with a colleague outside the study hospital prior to data collection and discussed the methodology and later the findings. This was done to ensure that the method used was seen as appropriate and that the findings were worthy.

The researcher further discussed the process to be undertaken in this study with the supervisor. The transcripts were also shared with the supervisor.

### 3.5.2 Dependability

The dependability of qualitative research refers to the reliability of data over time and over conditions (Lincoln & Guba 1985:230). The researcher will keep the audio-taped information taken during interviews and raw data transcript and reports for the dependability audit. This documentation is open to scrutiny by the supervisor and external reviewers (Polit & Beck 2008:539).

The researcher gave the transcripts and field notes to the independent coder who did not participate in this study to analyse and interpret them. Both the researcher and the independent coder reached a consensus. According to Polit and Beck (2012:175), the researcher presented the research to colleagues and specialists in the area to determine its coherency. In this study, my supervisor who is a specialist in psychiatric mental health nursing verified the results and two colleagues who also read the findings and found them to be coherent.
3.5.3 Transferability

Transferability refers essentially to the generalisability of the data, the extent to which findings can be transferred or be applicable to other settings (Polit & Beck 2008:548). In this study, the researcher used a nominated sample and dense descriptions to ensure transferability.

3.5.3.1 Nominated sample

Purposive sampling was used for the selection of the research participants. The researcher interviewed general nurses who have not been trained in psychiatric nursing and yet nursing psychiatric patients.

3.5.3.2 Dense descriptions

Data about participants, the research context and the setting was adequately provided. This was to provide rigour and a comprehensive decision trail that potential stakeholders for this study might find relevant.

3.5.4 Confirmability

Confirmability refers to objectivity, which is the potential for congruence between two or more independent people about data’s accuracy, relevance or meaning (Polit & Beck 2008:539). Researchers (Polit & Beck 2008:539; Gerrish & Lacey 2010:140) all agree that confirmability is very difficult for any researcher to maintain. In this study, the researcher set aside any preconceived ideas that she had so as to prevent biasness. The researcher was also sensitive that her believes about the topic should not interfere with the study. The findings of the study were also attenuated with direct quotes from the participants as evidence of the information provided.

3.6 DATA ANALYSIS

Polit and Beck (2012:556) define data analysis as the process of organising, and providing structure to the data with the aim of eliciting meaning from the data collected.
In qualitative studies, data analysis occurs at the same time with data collection (Streubert & Carpenter 2011:92).

Data analysis begins with the researcher arranging the data for analysis. This data is then condensed into themes through the process of coding and the codes and finally presenting the themes in figures, tables and charts or as discussion (Creswell 2007:146). Qualitative analysis is viewed as fitting data together and making the unconquerable evident (Morse & Field 1996:120).

The researcher used the Tesch’s method as described by Creswell (2003:192). The researcher immersed herself in the data by reading the transcripts over and over again to get a complete feel of what is contained in the transcripts. Tesch's method of data analysis was used for this study (Creswell 2003:192).

**Step 1:** Researcher listened to the recorded interviews many times and took notes. These ideas were then written down and compared with non-verbal expressions noted during the interviews.

**Step 2:** One recorded interview was selected and listened to understand the underlying message. During the listening process, the researcher documented a few memos for the purpose of identifying possible categories.

**Step 3:** This step involves the coding of themes and sub-themes. A code in qualitative inquiry is a word or short phrase that symbolically assigns a summative, salient, essence capturing and/or evocative attribute for a portion of language based or visual data (Strauss 1987:27). Each piece of data was classified. The researcher grouped the topic according to emerging themes and sub-themes.

**Step 4:** This step is a process of generating themes that emerged from Step 3. Streubert and Carpenter (2011:46) define a theme as “an abstract entity that brings meaning identity to a recurrent experience and its variant manifestations”. Themes describe settings, people and categories. Themes listed above were then given codes and compared and contrasted to ensure that nothing had been left out. At this stage, the researcher sent out the results of the preliminary coding to her supervisor and an
independent coder and the results were compared and differences discussed until consensus was reached.

**Step F5:** The researcher then condensed the themes into categories, which are specific templates that group similar themes together. In this study, three themes were categorised according to similar clusters of information.

**Step 6:** The researcher finalised each category and arranged codes alphabetically. In several instances, direct quotes from participants were selected and italicised. This process was used to illuminate the participants’ descriptions of their lived experiences of being general nurses working with psychiatric patients without any training.

### 3.7 METHODOLOGICAL ISSUES AND LIMITATIONS

Methodological issues and potential limitations arose from the sample size and the data collection method. The sampling technique used in this study is purposive sampling. A randomised sampling technique was not appropriate because the aim of the study was not to achieve representation and generalisation of the findings.

In-depth interviews place the participants in a subordinate position and the interviewer always has power over the participants. Since the researcher works in the study hospital as a more senior person than the participants and being a trained psychiatric nurse herself, this may have unduly intensified the subordination position of participants. As a result, the participants might have responded differently. However, the researcher had built a researcher/participant relationship divorced from the day-to-day working relationship with each participant.

### 3.8 CONCLUSION

Chapter 3 discussed, in detail, the research design and methodology. The qualitative descriptive design used in this study provided a rich description of the participants, lived experiences of being general nurses working with psychiatric patients using their own words, in a familiar environment.
A detailed description of the sampling process, eligibility criteria pilot testing, data collection and data analysis are presented. Issues of trustworthiness are also discussed in detail in this chapter. The chapter ended with the methodological issues and potential limitations related to this methodology.
CHAPTER 4

STUDY FINDINGS

4.1 INTRODUCTION

This chapter presents the findings of the lived experiences of general nurses working with psychiatric patients without relevant training. The participants described their lived experiences and proposed ways that could alleviate or improve their situation. The chapter will first give the demographic analysis of the participants.

4.2 DEMOGRAPHIC DATA OF PARTICIPANTS

Demographic information in qualitative studies supports the details about the participants' findings on the aspect of study (Lara-Cinisomo, Fuligni, Daugherty, Howes & Karoly 2009:5). Demographic information is therefore necessary to inform the reader on who actually gave the information. Table 4.1 shows the characteristics of participants.

Table 4.1 Demographic characteristics of participants

<table>
<thead>
<tr>
<th>Participant</th>
<th>Gender</th>
<th>Age</th>
<th>Qualification</th>
<th>Years of experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>GN 1</td>
<td>Female</td>
<td>67</td>
<td>General nursing with midwifery</td>
<td>17</td>
</tr>
<tr>
<td>GN 2</td>
<td>Female</td>
<td>57</td>
<td>General nursing</td>
<td>6</td>
</tr>
<tr>
<td>GN 3</td>
<td>Female</td>
<td>30</td>
<td>General nursing</td>
<td>1 year, 9 months</td>
</tr>
<tr>
<td>GN 4</td>
<td>Female</td>
<td>35</td>
<td>General nursing</td>
<td>3</td>
</tr>
<tr>
<td>GN 5</td>
<td>Female</td>
<td>42</td>
<td>General nursing with midwifery</td>
<td>7</td>
</tr>
<tr>
<td>GN 6</td>
<td>Female</td>
<td>45</td>
<td>General nursing with midwifery</td>
<td>5</td>
</tr>
<tr>
<td>GN 7</td>
<td>Female</td>
<td>59</td>
<td>General nursing</td>
<td>3</td>
</tr>
</tbody>
</table>

Seven general nurses working in the study hospital, which gives a 72-hour observation for psychiatric patients was interviewed. All the participants were female nurses with their ages ranging from 30 to 67 years.
The participants were all qualified nurses, and three out of the seven had a midwifery qualification. Their experiences of working with psychiatric patients ranged from almost two years to 17 years.

4.3 EMERGED THEMES

The three themes that emerged show the contextual nature and the interrelationships in the participants’ descriptions of their lived experiences of nursing psychiatric patients while not trained to do so. Figure 4.1 shows the three themes and the five sub-themes that emerged from the study.

![Figure 4.1 Themes and sub-themes from participants' interviews](image)

4.3.1 Perceived danger due to aggression

All participants mentioned stress related to perceived aggression from psychiatric patients. The participants said that they, as well as other patients and their families, are
stressed by that the psychiatric patients share the same wards as other patients who do not have psychiatric conditions.

4.3.1.1 Stress for medical patients

Participants mentioned that the other medical patients in the wards are scared of psychiatric patients. Quotes that relate to the danger among other medical patients are as follows:

General Nurse (GN) one with 17 years’ experience said:

“Other patients are scared of psychiatric patients, when they (psychiatric patients) become aggressive all of them stand up and those that are bed ridden just stare in fear.”

GN 4 with three years’ experience said:

“Medical patients do not want psychiatric patients in the ward. They are scared, that they might hurt them.”

GN 5 with seven years' experience said:

“Medical patients are scared to sleep; psychiatric patients grab bed-ridden patients on their neck.”

4.3.1.2 Stress for medical patients’ families

Family members of medical patients are scared that psychiatric patients might hurt their relatives since they are all nursed in the same wards. This was best espoused by the following quotes:

GN 4 with three years’ experience said:

“Medical patients’ relatives complain and ask why medical patients are nursed in the same wards as psychiatric patients.”
GN 6 with five years’ experience said:

“Relatives of other medical patients do not understand why their relatives who are not “mad” are nursed in the same wards as psychiatric patients.”

GN 3 with almost two years’ experience said:

“One patient’s worried relative said that one day he walked in the ward and found his relative having been assaulted by a psychiatric patient. He said that he was scared that the psychiatric patient would kill him”.

GN 6 with five years’ experience said:

“I perceive psychiatric patients to be dangerous and I am worried that I cannot see the warning signs that the patient is going to be dangerous.”

4.3.1.3 Stress for nurses

The nurses’ stress was very palpable during the interviews. The nurses said they are under so much pressure to explain things to other patients’ families, to the patient themselves and to also render good nursing care for psychiatric patients. The following quotes attenuate the stress felt by the nurses:

GN 1 with 17 years’ experience said:

“Patients, nurses and other workers are in danger especially if they are not trained”.

GN 7 with three years’ experience said:

“I don’t leaving dangerous things like glasses and matches next to psychiatric patients. Some patients act cool as if everything is fine but when you turn around they assault you. Psychiatric patient continued to threaten.”
GN 3 with almost two years’ experience said:

“We get psychiatric patients who are aggressive and they threaten to beat us, especially male patients”.

GN 4 with three years’ experience perceived psychiatric patients as extremely dangerous. She said:

“When psychiatric patients fight us and other patients we call security guards to come and assist.”

She even expressed herself in Zulu, saying:

“I usually tell my colleagues that uhlanya luyingozi lingakubulala meaning that a psychiatric patient is dangerous and can kill you”.

GN 5 with seven years’ experience said:

“Psychiatric patients are aggressive and it is your responsibility as a sister to calm the patient down and get him out of the way of other patients in order to prevent injury to other patients and staff”.

4.3.1.4 Stress for nurses

The nurses’ stress was very palpable during the interviews. They said that they were under so much pressure to explain things to the other patients’ families and to the patient themselves and to also render good nursing care for psychiatric patients. The following quotes attenuate the stress felt by the nurses for themselves:

GN 1 with 17 years’ experience said:

“Patients, nurses and other workers are in danger, especially if one is not trained”.
GN 7 with three years’ experience said:

“I don’t leave dangerous things like glasses and matches around psychiatric patients because I had a bad experience in the past. Some patients act cool, as if everything is fine, but assault you when you turn your back. Psychiatric patient continue to threaten us.”

GN 3 with almost two years’ experience said:

“We get psychiatric patients who are aggressive, especially male ones, who threaten to beat us.”

4.3.2 A lack of skills in dealing with psychiatric patients

General nurses find it difficult to care for psychiatric patients because they lack the communication and interviewing skills necessary in dealing with them.

4.3.2.1 Use of restraints

Participants reported that they used restraints when dealing with psychiatric patients. They felt that they would not resort to restraints had they been trained. One of the nurses said it looked “barbaric” to call security to come and restrain patients. Quotes listed below explain the frustrations that general nurses feel because of a lack of skills in working with psychiatric patients; and why they resort to using physical restraints.

GN 1 with 17 years’ experience said:

“We rely on doctors’ prescription. It is difficult to nurse them if one is not trained. It’s better to have trained psychiatric nurses because they come with new ideas and restraints.”

GN 2 with six years’ experience said:

“It is difficult to give medication if you are a female nurse. Male patients are not afraid of us. We have to ask for help and call security. I do not have necessary skills. The medical ward must admit medical patients, not psychiatric patients.”
GN 3 with almost two years’ experience said:

“The way we communicate with these patients may be provoking some anger in
them, we need to be trained so that we know how to talk to them and calm them
down.”

GN 4 with three years’ experience said:

“We don’t know how to manage psychiatric patients as we are not trained.
Sometimes they fight and destroy property and we don’t know how to handle
them. It is hectic to nurse these patients.”

GN 5 with seven years’ experience said:

“Referral hospitals do not accept psychiatric patients; they send them back to us
even if the problem is just some paper work that was not correctly filled. What
must we do with psychiatric patients? We do not have skills and equipment that
they have, so we continue to restrain them. I need restraints in order to cope.
They help me a lot. What should I do with aggressive patients?”

GN 6 with five years’ experience said:

“Nursing a psychiatric patient is difficult because you don’t know how to assist
them. You won’t see warning signs before the patient becomes aggressive; it is
really difficult. I cannot see the warning signs that the patient is going to be
dangerous because I do not have the skills”.

GN 7 with three years’ experience said:

I do not have the experience to deal with psychiatric patients. Not all patients are
aggressive it is just that you cannot trust a psychiatric patient if you are not
skilled”.

All the participants in this study decried a lack of skills as a serious hindrance to
providing care to psychiatric patients.
4.3.3 Self fulfilling prophecy

The following incidences were reported by participants. According to them, psychiatric patients are dangerous and they should not be nursed in the same ward as other medical patients.

GN 1 with 17 years’ experience related:

“At one point there were three male psychiatric patients admitted in the ward at the same time, they grouped themselves together and caused chaos. They locked themselves in the bathroom and opened taps”.

GN 3 with almost two years’ experience said:

“It is difficult to nurse psychiatric patients because they are aggressive and we are scared of them. They destroy property and when we phone the matrons they would say ‘phone the doctor on call’ and he would just say ‘continue to give them medication’ and never comes to assess the patients.”

GN 5 with seven years’ experience related this incidence:

“Psychiatric patients grab bed-ridden patient by their necks. One can manage to stop them if one is near. Sometimes they open taps, play with water and make the place dirty just to look for attention. They also abscond if they have stayed for too long in the hospital with their families not coming to fetch them.

“One psychiatric patient getting an injection decided that it is our turn to get it, he then took used needle and syringe and tried to inject us. We ran out of the ward scared, thinking of the chances of being infected with HIV. Eventually we came back and locked the patient out, although he used the sluice room door to come back again. The same patient assaulted a nurse at some stage. At one night, I had an aggressive patient who destroyed property; luckily there was a general practitioner in the ward, who helped me to restrain the patient.”
GN 6 with five years’ experience related this incident:

“A patient burned down a cubicle and went out shouting as if someone else had started the fire. The patient was confused, wanting to go inside the burning cubicle. I asked other nurses to extinguish the fire, while I kept an eye on him and other patients. Other patients were scared when they saw the flames”.

GN 7 with three years’ experience related this incident:

“Just before we left his room while taking the report from the night staff, a patient took a glass and tried to assault us, luckily it hit the wall. We removed other glasses and a matchbox next to him. He hid another matchbox and a few minutes later I saw smoke coming from his cubicle. I asked the police to unlock the cuffs because his bed, screen curtain, wall and the ceiling were on fire. The police officer said he did not have the key and I used the fire extinguisher to stop the fire. The patient continued to threaten us saying that that was nothing and there was more to come and that he wanted to burn all of us one-by-one.”

According to participants, key to nursing psychiatric patients is education or training. Participants felt that they would be more effective in caring for psychiatric patients if they are relevantly trained.

4.4 PROPOSED SOLUTIONS

Participants had different opinions about admission of psychiatric patients in medical wards. There were two very strong opinions on what could be done to resolve the problem. One of them was the suggested in-service training for general nurses and the second one was not mixing psychiatric patients with those that do not have a psychiatric diagnosis.

GN 1 with 17 years’ experience said:

“There must always be a psychiatric nurse on duty day and night duty because things have changed. It is better to have psychiatric trained nurses because they have new ideas regarding the use of restraints.”
GN 2 with six years’ experience said:

“A medical ward must admit medical patients. We must admit psychiatric patients but not in medical wards”.

GN 3 with almost two years’ experience said:

“We do not have the skills of working with psychiatric patients. We need in-service training on how to deal with and handle psychiatric patients. We need skills on how to communicate with them.”

GN 4 with three years said:

“From casualty, patients must go to psychiatric hospitals not our wards. We need training even if it is a five-day course that gives us an idea on how to handle these people because they are very aggressive on arrival.”

4.5 CONCLUSION

The three major themes and five sub-themes from the general nurses working with psychiatric patients were presented. The results illustrate that general nurses feel inadequately trained to nurse psychiatric patients – who are viewed as being aggressive.

This view has also been realised in that one of the themes was that of a self-fulfilling prophecy. There was no difference between the nurses with less and those with more years of experience. The uncertainties of nursing psychiatric patients without training were the same for all. Chapter 5 will discuss the findings of the study in reference to literature.
CHAPTER 5

DISCUSSIONS OF THE MAJOR FINDINGS OF THE STUDY

5.1 INTRODUCTION

This chapter discusses the major findings of the study as they relate to its purpose of exploring the lived experiences of general nurses caring for psychiatric patients.

The findings of this study support what is already known in literature as discussed in Chapter 2. These findings are not surprising as they demonstrate the plight of general nurses who are not trained to work with psychiatric patients but continue to do so. The study findings further accentuate what is already known about the labelling that goes with psychiatric patients and aggression as a resultant effect.

5.2 DISCUSSIONS

There are three themes that emerged from current study: perceived danger, a lack of skills in dealing with psychiatric patients and self-fulfilling prophecy.

5.2.1 Perceived danger

The literature on psychiatric patients notes that there is a widespread idea that the mentally ill are not only different from the rest of the patients, but that they are also dangerous (Heilbrun & Heilbrun 2006:39; Walker & Reinter 2007:67; Williams, Thornby & Sandlin 1990:21). This view has been supported in this study.

All seven participants perceived psychiatric patients as dangerous which causes stress to the nurses, medical patients and the patients’ families. The findings of the current study are consistent with the previous study of Mavundla (2000:1575), where nurses revealed that psychiatric patients threatened them and other patients. They also perceived psychiatric patients as dangerous. Lethoba et al (2006:5) also stated that there’s a common belief that psychiatric patients are potentially dangerous.
Rueve and Welton (2008:34) reported that mental illness and violence are often seen as inextricably linked and this has led to the stigma associated with mental illness. This study by Rueve and Welton further reported that psychiatric patients who get admitted in general hospitals display violent behaviour, which in itself perpetuates the already existing stigma associated with psychiatric patients and a voice for their isolation. Participants in the current study suggested that psychiatric patients be isolated from the general wards as they are a threat to patients, families, as well as the nurses.

Bimenyimana et al (2009:5) stated in his study that psychiatric patients are admitted because they display aggressive behaviour and pose danger to themselves, other people and property. Reed and Fitzgerald (2005:251) revealed that participants were threatened because there was a lack of control over the situation yet they had responsibility to maintain the health and safety of other patients.

5.2.2 Lack of skills in dealing with psychiatric patients

The study revealed that all participants appreciated the fact that dealing with psychiatric patients is totally different from dealing with medical patients. They verbalised a lack of knowledge and skills necessary for nursing psychiatric patients. Some even resorted to restraining the patients because sometimes the drugs are not effective. Participants said that they did not know how to manage psychiatric patients because they were not trained in psychiatric nursing. A certain participant said that she could not read the warning signs of a patient who is about to get dangerous.

The findings of this study concurred with those of previous studies. Mavundla (2000:1570) stated that:

"In South Africa’s general hospitals, most nurses are not psychiatric trained. These nurses consider themselves to be inadequately equipped to nurse psychiatric patients effectively. Owing to their lack of knowledge about psychiatric illness in patients, they encounter, and at times, they would even go further to conclude that the condition of a patient is due to dagga or pretence. As a result of their speculations these are generally uncertain about the patient’s condition. This leads to these nurses inability to read the warning signs of violence within their units".
A study by Sharrock and Happell (2005:10) revealed that there is evidence that general nurses perceive themselves as lacking knowledge in assessment and management of psychiatric patients, and that it is difficult for them to render care that will meet the patients’ needs.

All participants expressed a lack of knowledge and skills regarding caring for psychiatric patients. Some even suggested that they needed training. These findings were also revealed in the previous study done by Aromaa (2011:3). It was stated that general nurses lack knowledge and skills needed for psychiatric patients, there was also a lack of assistance, which led to a need for ongoing education to enable them to render effective patient care. In her study, Lethoba et al (2006:5) said that most nurses in general wards were not psychiatric trained, which made the situation even worse. General nurses considered themselves inadequately trained to manage psychiatric patients; hence they failed to identify warning signs and symptoms of violence.

5.2.3 Self-fulfilling prophecy

Self-fulfilling prophecy as seen with psychiatric patients in the study is a result of labelling (Pasma 2009:1). The psychiatric patients know that they are expected to be difficult and violent. It is within this premise that psychiatric patients act in ways that are unacceptable in order to fulfil this expectation (Corrigan 2007:33).

It was revealed in the study that participants had preconceived ideas about psychiatric patients; they perceived psychiatric patients as dangerous and unpredictable. The incidences which occurred while they were on duty, such as psychiatric patients burning down cubicles and destroying property, proved to them that they indeed are dangerous.

Reed and Fitzgerald (2005:255) also found in their study that participants were concerned and perceived psychiatric patients as dangerous and unpredictable. Negative past experience influenced the participants behaviour around psychiatric patients. Some participants were more cautious by removing things such as glasses and matchboxes away from patients. This concurred with the study conducted by Ashmore et al (2006:562), which stated that negative experiences influence the nurse’ perception on psychiatric patients and the care they deserve. It also affects their view of their competency in providing patient care.
Participants observed the aggression from psychiatric patients from the stated incidents in Chapter 4, where one psychiatric patient grabbed a bedridden patient by the neck, and some psychiatric patients assaulted nurses and wanted to inject them with used needles and syringes.

These findings concurred with the study of Mavundla et al (1999:35), which stated that violence in general wards results in loss of lives, fear, infection with HIV and physical assaults, that leave emotional scars in the nurses employed in these settings.

Participants stated that the presence of psychiatric patients in medical wards is not appropriate. Medical patients and families do not want psychiatric patients in medical wards; they are scared of them. Psychiatric patients must be transferred to psychiatric hospitals straight from casualty. Mavundla (2000:1570) alluded in his study that general nurses felt that the presence of psychiatric patients in the wards was perceived as a hindrance which interferes with their duties. The presence of psychiatric patients made the nurses unhappy.

Generally, the emotional atmosphere in the wards where psychiatric patients are admitted may have been the cause or at least contributed in part to the aggressive behaviour of psychiatric patients. This assertion has only been linked to family rejection of psychiatric patients and not the nurses’ (Krelsman, Simmons & Joy 1999:220).

5.3 CONCLUSION

Violence from psychiatric patients poses tremendous risks and challenges for general nurses, other patients and their families. The concern for the general nurses’ safety is a reality that is supported in literature. The next chapter will discuss the study limitations, recommendations and general conclusions for the study.
CHAPTER 6

CONCLUSIONS LIMITATIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

The preceding chapter discussed the major findings of the study. The chapter also situated the study findings to available literature. This chapter presents the summary of the study. Limitations, strengths and recommendations for the study are made and presented in this chapter.

6.2 CONCLUSIONS

This study explored the lived experiences of general nurses who care for psychiatric patients. By examining this phenomenon, the researcher attempted to provide insight into the experiences of being placed in an area where you are least qualified. Both grey and current literature was used to understand the experiences of general nurses looking after psychiatric patients.

The study found that a lack of skills, perceived danger and self-fulfilling prophecy instils stress to patients, patients’ families and the nurses. The findings of the study accentuate what is already known in literature. Surprisingly, very few studies were done in South Africa. Studies done more than two decades ago (Basheer 1998; Mavundla & Uys 1997; Mavundla 2000) also reiterated the need for training in psychiatric nursing. These studies were followed by Lethoba et al (2006) and Bimenyimana et al (2009), which made similar recommendations that nurses should be trained to provide quality nursing care to psychiatric patients. To date, nurses still find themselves having to care for psychiatric patients while they are not trained to do so.

The current study recommends strategies for improvement of care to psychiatric nurses through education, practice and research. These recommendations are given at the end of this chapter.
The findings of this study have potential to make a significant contribution to extant knowledge concerning the lived experiences of general nurses who are expected to render care to psychiatric patients and who at times are judged by what they do not know.

6.3 STUDY LIMITATIONS AND STRENGTHS OF THE STUDY

6.3.1 Limitations of the study

This study investigated the lived experiences of general nurses caring for psychiatric patients in two medical wards of one hospital. Therefore, the findings were contextualised within one institution. This study cannot be generalised because of the limited number of participants who participated in the study.

Another limitation to the study was that the lived experience was captured at a single point in time. It is possible that the participants’ perceptions could have been later modified.

The interviews were done in English, which is a second language for all participants including the researcher. Even though English is an official language, expressing oneself in a second language is not the same as expressing oneself in one’s mother tongue.

The researcher chose which “voices” to report on this study and may have left out certain ones that might have been meaningful to others. Lastly, the researcher works in the same institution as the research participants. Therefore, an element of bias cannot be totally excluded.

6.3.2 Strengths of the study

The phenomenological approach used in the study is its strength. This approach gave participants a vehicle to describe in their own words their own experiences of nursing psychiatric patients whereas they are not trained to do so. Their stories gave the researcher an overview of what they experience on their day-to-day encounters with psychiatric patients.
6.4 RECOMMENDATIONS

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

6.4.1 Recommendation for future research

This current study will serve as a base where future studies can be made. It would also be beneficial if similar studies could be done in other institutions in order to give reliable empirical evidence that can inform policies.

6.4.2 Recommendation for policy

Recommendations will be made that in future, before the implementation of policy, proper situational analysis must be done to ensure enough psychiatric trained nurses in medical wards. In addition, the infrastructure of medical wards must be assessed if it is conducive to nurse psychiatric patients.

6.4.3 Recommendation for nursing education

The role of nursing education institutions is to provide information that positively informs practice. Education institutions should provide psychiatric training so that all nurses would know how to interact with psychiatric patients. Such knowledge will prevent the stigmatising attitudes, which in turn, provoke patients to become aggressive.

The findings of the current study highlight the need for the training of general nurses. They need professional interview and communication skills needed for dealing with psychiatric patients.

It will also be recommended that continuous in-service training be done by showing videos used in training colleges, to allay anxiety and improve knowledge and skills in nursing psychiatric patients.
6.4.4 Recommendation for practice

Psychiatric nursing is a specialised area. Allocation of nurses in the wards should always include psychiatric trained nurses. Violence by psychiatric patients is not only meted out to those not trained, but those trained would probably assess aggressive behaviour and prevent it by calming the patients. Allocating trained nurses will also promote the care given to psychiatric patients. They will be better situated to allay other patients’ anxieties.

6.5 CONCLUSION

Chapter 6 gave a summary of the study purpose, objectives and the methodology used in the study. Study limitations and recommendations are also given in the chapter. The overall finding is that non-trained psychiatric nurses feel inadequate to nurse psychiatric patients and view them as being aggressive, which in itself compromises care.
REFERENCES


Morse, JM & Field, P. 1996. *Nursing research: the application of qualitative approaches*. CA: Sage


Annexure A

Ethical clearance from Department of Health Studies Research and Ethics Committee, College of Human Sciences, University of South Africa (UNISA)
Annexure B

Request for permission to Mpumalanga Department of Health to conduct the study
Annexure C

Permission to conduct the study obtained from Mpumalanga Department of Health’s Ethics Committee
Annexure D

Request for permission to Standerton Hospital to conduct the study
Annexure E

Permission to conduct the study obtained from the study hospital management
Annexure F

Consent form to participants
Annexure G

Editor's letter
Standerton Hospital
Private Bag X 2003
Standerton
2430

Dear Sir/Madam

REQUEST FOR A PERMISSION TO CONDUCT A STUDY AT STANDERTON HOSPITAL

I hereby request permission to conduct a study at Standerton Hospital. My name is Nozipho Felicity Gule currently studying Masters Degree at the University of South Africa. As one of the requirements for masters degree I have to write dissertation and do research as part of my studies.

The title of the study is: Experiences of General Nurses working in Standerton Hospital Medical Wards designated to be 72 hour assessment units for psychiatric patients. I have attached the clearance certificate from University of South Africa and the research proposal summary sheet.

Thank you

Nozipho Felicity Gule
Persal number: 14819350
P.O. Box 1698
Standerton
2430
30 July 2012

Mpumalanga Department of Health
Ethics Committee
Private Bag X 11213
Nelspruit
1200

Dear Sir/Madam

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Thank you

Nozipho Felicity Gule

Persal number: 14819350

[Signature]
10 May 2013

Ms. Nozipho Gule
P.O Box 1698
Standerton
2430

Dear Ms. Nozipho Gule

APPLICATION FOR RESEARCH & ETHICS APPROVAL: EXPERIENCES OF GENERAL NURSES WORKING IN STANDERTON HOSPITAL MEDICAL WARDS DESIGNATED TO BE 72 HOURS ASSESSMENT UNITS FOR PSYCHIATRIC PATIENTS

The Provincial Research and Ethics Committee has approved your research proposal in the latest format that you sent.

Kindly ensure that you provide us with the soft and hard copies of the report once your research project has been completed.

Kind regards

Mr. Molefe Machaba
Research and Epidemiology

Date

10/05/2013

We care... Do you?
e) Supervisor/ co-supervisor (In the case of research undertaken as part of an academic requirement)

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f.) Medical Manager (Please obtain the approval of the Hospital Superintendent if any of your research will involve specific hospital personnel, equipment, data, etc.)

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g.) District Manager/CEO (Please obtain the approval of the District Manager/CEO in charge of the particular district in which your research is intended to take place).

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h.) Chief Director Hospital Services/ Primary Health Care.

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i.) Please list any other involved department/ institution/ facility heads involved in your research.

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| Nil        |                                  |           |
|           |                                  |           |
WHAT ARE MY RIGHTS AS A PARTICIPANT IN THIS STUDY

Your participation in this study is voluntary, that means you do not have to be part of the study if you do not want to. If you said you will participate and you change your mind, it will be fine. You can stop at anytime.

WILL THE STUDY PROCEDURES HURT ME?

The study and procedures involve no foreseeable physical discomfort. However, as a participant you may experience some sad emotions as you go through your experience of working with psychiatric patients. If you feel so, you need to report to the researcher who will immediately refer you for supportive counselling.

WHAT ARE THE RISKS INVOLVED IN THE STUDY

The study procedures involve no foreseeable risk to you or your family.

CONFIDENTIALITY

All information obtained during the course of this study is strictly confidential. Your identity will not be revealed when the study is reported in scientific journals. All the data that has been collected will be stored in a secure place and will not be shared with any other person without your permission. The audio-taped recordings and any other data will be kept under lock and key.

INFORMED CONSENT

I hereby confirm that the investigator has informed me about the nature, conduct, benefits and risks of the study. I have also received, read and understood the above written information (participant information and informed consent) regarding the study.

I am aware that the results of the study, including personal details regarding my age, race, qualifications and years of experience as a professional nurse will be anonymously processed into a research report.

I may, at any stage, without prejudice, withdraw my consent and participation in the study. I had sufficient opportunity to ask questions and of my own free will declare myself prepared to participate in the study.

Participant’s name: ___________________________________________ (please print)

Participant’s signature: ___________________________ Date: ________________

Investigator’s name: ___________________________________________ (please print)

Investigator’s signature: ___________________________ Date: ________________
This serves to confirm that I, Refilwe Thobega, edited the thesis of: Felicia Gule titled: Lived Experiences of General Nurses Working at Standerton Hospital Medical Ward Designated to be a 72-hour Assessment for Psychiatric Patients.

November 2013.