COMPREHENSIVE APPROACH TO CONTINUING PROFESSIONAL DEVELOPMENT OF REGISTERED AND ENROLLED NURSES AT A PSYCHIATRIC REHABILITATION CENTRE

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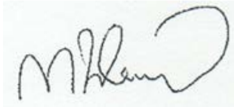
DECLARATION

I declare that **COMPREHENSIVE APPROACH TO CONTINUING PROFESSIONAL DEVELOPMENT OF REGISTERED AND ENROLLED NURSES AT A PSYCHIATRIC REHABILITATION CENTRE** is my own work and that all the sources I have used and quoted have been acknowledged through complete referencing.



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ABSTRACT

The study sought to gain an in-depth understanding of the knowledge and skills regarding rehabilitation of mental health care users of nurses who work at a psychiatric rehabilitation centre, in order to design a continuing professional development plan for registered and enrolled nurses.

The researcher used a qualitative, exploratory descriptive design to explore the knowledge and skills of nurses who practise in a psychiatric rehabilitation centre dealing with the rehabilitation of mental health care users.

Four themes emerged from the data that were collected from four focus groups: knowledge of the rehabilitation process; the need for continuing professional development; nursing skills required for the implementation of psychiatric rehabilitation and means of communication within psychiatric rehabilitation.

The researcher devised a continuing professional development plan, including topics on the management of the mentally ill, the problems associated with mental illness and rehabilitation appropriate to the mental illness

KEY CONCEPTS

Knowledge of nurses, skills of nurses, continuing professional development, mental health, rehabilitation.

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Table of contents Page

CHAPTER 1

INTRODUCTION AND OVERVIEW OF THE STUDY

1.1 INTRODUCTION ... 1

1.2 RESEARCH PROBLEM ... 2

1.2.1 Background to the problem ... 3
1.2.2 Statement of the research problem ... 5

1.3 RESEARCH PURPOSE ... 6

1.3.1 Research objectives ... 6

1.4 SIGNIFICANCE OF THE STUDY ... 6

1.5 DEFINITION OF KEY CONCEPTS ... 7

1.6 RESEARCH METHODOLOGY ... 8

1.6.1 Research design ... 8
1.6.2 Population ... 8
1.6.3 Selection of participants ... 9

1.7 RESEARCH SETTING ... 9

1.8 DATA COLLECTION ... 9

1.8.1 Data collection instrument ... 10
1.8.2 Data analysis ... 10

1.9 TRUSTWORTHINESS ... 10

1.10 ETHICAL CONSIDERATIONS ... 10

1.10.1 Protecting the rights of the participants ... 11

1.10.1.1 Informed consent ... 11
1.10.1.2 Confidentiality ... 11

1.10.2 Rights of the institution ... 11
1.10.3 Scientific integrity of the researcher ... 11

1.11 SCOPE AND LIMITATIONS ... 12

1.12 STRUCTURE OF THE DISSERTATION ... 12

1.13 CONCLUSION ... 13

Table of contents Page

CHAPTER 2

RESEARCH METHODOLOGY

2.1 INTRODUCTION 14

2.2 PURPOSE OF THE STUDY 14

2.3 RESEARCH DESIGN 14

2.3.1 Qualitative research 15
2.3.2 Exploratory descriptive design 16

2.4 RESEARCH METHODS 16

2.4.1 Research setting 16
2.4.2 Population 17
2.4.3 Sampling 17

2.5 DATA COLLECTION 18

2.5.1 Focus groups 18
2.5.2 Preparing for the focus groups 19
2.5.3 Facilitation of the focus groups 19

2.6 DATA ANALYSIS 20

2.7 TRUSTWORTHINESS 21

2.8 ETHICAL CONSIDERATIONS 23

2.8.1 Permission to conduct the study 23
2.8.2 Ethical principles 23

2.8.2.1 Principle of beneficence 23
2.8.2.2 Principle of justice 23
2.8.2.3 Principle of autonomy 24

2.9 CONCLUSION 24

CHAPTER 3

PRESENTATION OF THE DATA

3.1 INTRODUCTION 25

3.2 DATA ANALYSIS 25

3.2.1 Biographical detail 26

Table of contents Page

3.3 THEMES 27

Theme 1: Knowledge of the rehabilitation process 27

3.3.1 The meaning of rehabilitation 28

Category 1: Returning to and functioning independently in the community 29
Category 2: Changing of lives 29
Category 3: Handling of people 30

3.3.2 Assessment of the mental health care users' functioning 30

Category 1: Determining the level of functioning 30
Category 2: Rehabilitation activities 31
Category 3: Information obtained on assessment 31

3.3.3 Planning of rehabilitation 32

Category 1: Plan according to problems identified 32
Category 2: Planning of individual rehabilitation 33

3.3.4 Implementation of activities 33

Category 1: Specific group activities 34
Category 2: Activities according to level of functioning 34
Category 3: Activities of daily living 35
Category 4: Activities for discharge 36

3.3.5 Implementation of education 36

Category 1: Education of the mental health care users 36
Category 2: Education of the family members 37

3.3.6 Evaluation of care users' response to rehabilitation 37

Category 1: Reasons for evaluation 38
Category 2: What evaluation entails 38

3.3.7 Multi-disciplinary team 39

Category 1: The role of the multi-disciplinary team in rehabilitation 39

3.3.8 Management of mental disorders 40

Category 1: Management of the signs and symptoms of mental illness 40
Category 2: Management of specific mental disorders 40

3.3.9 Therapeutic relationship with mental health care users within the rehabilitation process 41

Category 1: Nurse-patient relationship 41
Category 2: Importance of knowing the mental health care user 41
Category 3: Acknowledgement that mental health care users should be treated with respect and dignity 42
Category 4: Understanding cultural and religious beliefs 42

Table of contents Page

Theme 2: The need for continuing professional development 43

3.3.10 The need for further knowledge 43

Category 1: Knowledge about behaviour shown by people who suffer from specific mental conditions 44
Category 2: Management of mental illnesses 44
Category 3: Substance abuse by mental health care users 45
Category 4: Specific rehabilitation activities 45
Category 5: Management of low-level functioning mental health care users 45
Category 6: Safety of staff members 46

Theme 3: Nursing skills required for the implementation of psychiatric rehabilitation 46

3.3.11 Interpersonal skills in nursing 47

Category 1: Skill of listening 48
Category 2: Skill of patience 48
Category 3: Skill of observation 49
Category 4: Skill of empathy 49
Category 5: Problem-solving skills 49

3.3.12 Rehabilitation skills 50

Category 1: Skills to communicate with mental health care users functioning at different levels 50
Category 2: Identification of a relapse 51
Category 3: Lack of understanding of an activity by a mental health care user 52
Category 4: Lack of understanding of an activity by nurses 52
Category 5: Implementation of sensory stimulation 53

Theme 4: Means of communication within psychiatric rehabilitation 53

3.3.13 Verbal communication 54

Category 1: Talking to the mental health care users 54
Category 2: Asking questions 55
Category 3: Allowing expression of feelings 55
Category 4: Interviewing mental health care users 55

3.3.14 Non-verbal communication 56

Category 1: Therapeutic touch 56
Category 2: Listening to the mental health care users 56
Category 3: Sign language 57
Category 4: Communication by low-level functioning mental health care users 57

3.3.15 Written communication 58

Category 1: Importance of record keeping 58
Category 2: Monthly reports 58

Table of contents Page

3.4 EMERGING RELEVANT OUTLIERS 59

Quotation 1: Special role of the psychiatric nurse 59
Quotation 2: Professional pride of a psychiatric nurse 59
Quotation 3: Psychiatric nursing as a profession........ 60

3.5 CONCLUSION........ 60

CHAPTER 4

FINDINGS AND COMPARISON WITH THE LITERATURE

4.1 INTRODUCTION 61

4.2 DATA ANALYSIS........ 61

4.3 DISCUSSION OF THE FINDINGS AND COMPARISON WITH THE LITERATURE........ 62

4.3.1 Knowledge of the rehabilitation process 62

4.3.1.1 The meaning of rehabilitation 62
4.3.1.2 Assessment of the mental health care users' functioning........ 63
4.3.1.3 Planning of rehabilitation 64
4.3.1.4 Implementation of activities 65
4.3.1.5 Implementation of education........ 68
4.3.1.6 Evaluation of care users' response to rehabilitation 69
4.3.1.7 Role of the multi-disciplinary team........ 69
4.3.1.8 Management of mental disorders 70
4.3.1.9 Therapeutic relationship with mental health care users within the rehabilitation process........ 70

4.3.2 The need for continuing professional development 73

4.3.2.1 The need for further knowledge........ 73

4.3.3 Nursing skills required for the implementation of psychiatric rehabilitation........ 76

4.3.3.1 Interpersonal skills in nursing........ 76
4.3.3.2 Rehabilitation skills 78

4.3.4 Means of communication within psychiatric rehabilitation........ 80

4.3.4.1 Verbal communication 80
4.3.4.2 Non-verbal communication........ 82
4.3.4.3 Written communication 85

4.4 EMERGING RELEVANT OUTLIERS 86

4.5 CONCLUSION........ 87

Table of contents Page

CHAPTER 5

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION 88

5.2 OVERVIEW OF THE STUDY 88

5.3 FINDINGS AND CONCLUSIONS 89

5.3.1 The rehabilitation process 89
5.3.2 The need for continuing professional development 89
5.3.3 Nursing skills required for the implementation of psychiatric rehabilitation 90
5.3.4 Means of communication within psychiatric rehabilitation 90

5.4 LIMITATIONS OF THE STUDY 90

5.5 RECOMMENDATIONS 91

5.5.1 Further research 91
5.5.2 Nursing education 91
5.5.3 Nursing practice 92

5.6 CONTINUING PROFESSIONAL DEVELOPMENT PLAN 92

5.7 CONCLUSION 93

LIST OF REFERENCES 95

List of tables Page

Table 2.1 Trustworthiness in qualitative research 21

Table 3.1 Biographical information 26

Table 3.2 Theme 1: Knowledge of the rehabilitation process 28

Table 3.3 Theme 2: The need for continuing professional development 43

Table 3.4 Theme 3: Nursing skills required for the implementation of psychiatric rehabilitation 47

Table 3.5 Theme 4: Means of communication within psychiatric rehabilitation 54

Table 5.1 Outline of a continuing professional development plan 93

List of abbreviations

CPD	Continuing Professional Development
MDT	Multi-disciplinary Team
MR	Mentally Retarded
OT	Occupational Therapy
OTA	Occupational Therapy Assistant
WHO	World Health Organization

List of annexures

Annexure 1 Information leaflet given to the participants

Annexure 2 Informed consent for participants

Annexure 3 Letter requesting permission to conduct the research study

Annexure 4 Permission letter from the hospital manager

Annexure 5 Permission letter from the College Senate Life Healthcare

Annexure 6 Department of Health Studies, Higher Degrees Committee, Unisa: Ethical Clearance Certificate

Annexure 7 Co-coder report

CHAPTER 1

INTRODUCTION AND OVERVIEW OF THE STUDY

1.1 INTRODUCTION

Health care is changing and becoming more complex. It encompasses caring for the physical and mental well-being of people. Mental health care refers to an extensive range of activities directly or indirectly related to the mental well-being of an individual. It involves the promotion of mental health, the prevention of mental disorders, treatment and rehabitablelitation of people affected by mental disorders (WHO 2013). Mental health care delivery in South Africa has followed international trends, changing from institutionalised care to care delivered to mental healthcare users in the community (South Africa 2002:4). The changed focus has created a need for mental health care nurses to obtain additional competencies and skills in the rehabilitation of mental health care users. Maintaining competence in the changing health care environment is every nurse's responsibility.

This can be realised through formal qualifications offered by universities and colleges, or informal training provided in the workplace. There is an agreement in the literature (Davids 2006:4) that continuing professional development (CPD) of nurses is an all-embracing term covering any learning experience that takes place after the initial education of the nurse. CPD contributes to the strengthening of knowledge, skills and behaviour once the initial training is completed (Leberman, McDonald & Doyle 2006:40), and enables the nurse to meet the special needs of patients with improved skills (Richards 2007:24). The requirement to function optimally in the changing professional environment compels nurses to adapt their knowledge and skills (Byrne, Delarose, King & Leske 2007:24). Richards (2007:25) points out, however, that there is a renewed importance being attached to it, with more emphasis being placed on continued learning within the profession of nursing. Professional nurses are expected to uphold their knowledge and skills throughout their professional careers.

The context of this study is a psychiatric rehabilitation centre where nurses are actively involved in the rehabilitation of mental health care users. The Mental Health Care Act (Act No 17 of 2002) contributed to restructuring and changes within the mental health care services in South Africa. The change to community-based care for people with mental health disorders emphasised the importance of rehabilitation (Moosa & Jeenah 2008:36) before care users were discharged back into the community.

To offer skilled and effective psychiatric nursing in different situations, nurses need access to appropriate CPD programmes (Morrissey & Callaghan 2011:61). Rehabilitation of mental health care users is multi-faceted and requires a range of competencies from health care practitioners. Attempts have been made to define the competencies that psychiatric rehabilitation practitioners need in order to be effective; in this regard some evidence has been found of the difference between the knowledge, attitudes and skills of novice and more experienced practitioners in relation to successful outcomes (Corrigan, Mueser, Bond, Drake & Solomon 2008:72). According to the International Society of Psychiatric Mental Health Nurses, a psychiatric mental health nurse, also known as a psychiatric rehabilitation practitioner, is a registered nurse who is educationally prepared in nursing and licensed to practise (Psychiatric Mental Health Nursing Scope & Standards 2006:13).

Rehabilitation of the care user focuses on the user's independence in terms of personal management, work and recreation. The maintenance of the person's quality of life and functioning and the environment and resources needed for growth and development are provided for through rehabilitation (Watson 2004:7-9). It is therefore very important that nurses keep up to date with the latest developments in rehabilitation.

1.2 RESEARCH PROBLEM

A research problem within nursing practice is a situation in need of change or an area of concern where a gap in the knowledge base of nursing practice occurs. Research is therefore conducted to generate knowledge in order to address the concern with the goal of providing evidence-based nursing care (Burns & Grove 2005:70).

1.2.1 Background to the problem

According to the International Council of Nurses (2008:2-3), about 500 million people worldwide suffer from mental disorders, and all people are at risk of mental health problems due to stressful lifestyles, dysfunctional relationships, civil conflict, violence, physical illness, infection or trauma. Nurses play a pivotal role in mental health promotion, prevention of mental health disorders, and the care, treatment and rehabilitation of people living with mental health problems. According to Burns (2010:662) about 14% of the global burden of disease can be attributed to neuropsychiatric disorders, such as depressive illness, anxiety disorders, substance abuse and psychotic disorders.

In sub-Saharan Africa the treatment of conditions such as HIV/AIDS, drug-resistant tuberculosis and the presence of co-morbid mental disorders is associated with high-risk behaviour, poor treatment adherence, and inability to access care. In South Africa the number of people suffering from mental illness or disabilities has increased. These include emotional disabilities, higher rates of alcohol and substance abuse and an increase in suicide attempts among the youth and the middle aged (South African Federation for Mental Health 2012:26).

The psychiatric rehabilitation centre where the study was conducted is one of five adult mental health facilities in a private hospital group providing treatment, care and rehabilitation to people suffering from mental illness. Mental health care users suffering from schizophrenia, schizo-affective disorder, bipolar mood disorder, dementia, co-morbid HIV and other physical conditions such as epilepsy, hypertension and tuberculosis, co-morbid substance abuse and intellectual impairment are admitted at the psychiatric rehabilitation centre.

Due to a shortage of registered nurses at the centre, enrolled nurses are employed to fulfil the same role as registered nurses in the care and rehabilitation of mental health care users. The shortage of registered nurses is not unique to the centre. Van Deventer, Couper, Wright, Tumbo and Kyeyune (2008:138-139) found that a shortage of specialised and knowledgeable staff to manage mental health care users exists in the North West province and that continuing professional development in psychiatry is needed to address this deficit. The effect of this has been that without the skills required

on the part of nurses, compliance with treatment has been difficult to ensure and the continuity has not been an important priority.

Research studies done by Moosa and Jeenah (2008:42) and Gourney (2005:6-11) support the notion that continuing professional development for nurses in psychiatric facilities is important to ensure that patients receive optimal care. Moosa and Jeenah (2008:42) state that mental health care services need to improve the mental health and wellbeing of the people they serve by promoting mental health awareness and teaching nurses appropriate skills. Their research in Gauteng, South Africa, found that trained health professionals in mental health are scarce. Mental health care is therefore delivered by nurses who have not specialised in mental health or psychiatric nursing and therefore might not be able to address all the needs of mental health care patients. Education in rehabilitation and the processes thereof will assist these nurses in providing optimal care. Gourney (2005:6-11) first conducted a study concerning the changes in psychiatric nursing in the United Kingdom in 1996. Nearly ten years later the researcher revisited the situation and found that despite many changes in the training provided to community psychiatric nurses, there was still little training available in managing conditions such as obsessive-compulsive disorder, post-traumatic stress disorder, severe panic disorder and agoraphobia. The researcher noted that there remained a shortage of skilled community psychiatric nurses and that only basic skills were emphasised.

The centre where this study was conducted has a policy that encourages continuing professional development of staff. The purpose of continuing professional development for nursing personnel at the centre is to develop and maintain abilities that will enable them to perform competently within their professional environment; to allow for personal and professional growth within the nursing profession; ensure compliance with legal requirements and assist nurses to acquire new and updated knowledge, skills and ethical attitudes (Life Healthcare 2011). The policy on rehabilitation addresses the assessment of mental health care users and the establishment and implementation of rehabilitation programmes (Life Esidimeni 2008a). This is in accordance with the Mental Health Care Act (Act No 17 of 2002), which stipulates that the nurse must provide care, treatment and rehabilitation to enable an individual to achieve an optimal level of independent functioning (South Africa 2002:5-6). Psychiatric rehabilitation can be defined as a therapeutic approach that allows mentally ill people to develop to their

fullest capabilities through learning and support (Corrigan et al 2008:50). Rőssler (2006:151) maintains that all patients suffering from severe and persistent mental illness require rehabilitation to help them develop the emotional, social and intellectual skills needed to live, learn and work in the community with the least amount of professional support. The competencies expected of psychiatric rehabilitation practitioners who are registered nurses (and enrolled nurses in this study) need to combine knowledge, skills, abilities, attitudes and judgement, so that they can help those with mental illness develop skills (American Nurses Association 2010:5). The literature supports the importance of rehabilitation for mental health care users (Corrigan et al 2008:50-54; Mauk 2012:1-2; Pan, Mellor, McCabe, Hill, Tan & Xu 2011:301, 304).

The researcher is a clinical training specialist at the rehabilitation centre. During formal evaluation of group work and the rehabilitation process at the psychiatric rehabilitation centre, the researcher observed some shortcomings in the provision of rehabilitation. It was observed that the activities which were selected and initiated by nurses were incorrect for the specific level of functioning according to the prescribed occupation performance areas. The researcher also observed a lack of behaviour modification being implemented for behaviour problems displayed by patients during the evaluations. Evaluation of record-keeping in the mental health care users' files indicated that nurses lacked knowledge and skills concerning rehabilitation of mental health care users. Comments and scoring found in the assessment tool used during evaluation were evidence of the lack of knowledge and skills indicated by the record keeping (Life Esidimeni 2008). The findings of the formal evaluation implied that nurses at the centre lacked knowledge and skills and/or were not familiar with the principles of psychiatric rehabilitation.

1.2.2 Statement of the research problem

During formal evaluation of nurses' knowledge and skill while implementing rehabilitation practices at a psychiatric rehabilitation centre, it was found that inappropriate rehabilitation strategies were applied (Life Esidimeni 2008). Assessment tools were used to evaluate the nurses on implementation of group activities and the rehabilitation process. The findings of the formal evaluation demonstrated that nurses at the centre lacked knowledge and skills of rehabilitation. Inappropriate rehabilitation procedures could impede the mental health care users' recovery and ability to obtain an

optimal level of independent functioning upon discharge from the centre. Therefore it is important that nurses at the centre have the knowledge and skills to implement appropriate rehabilitation strategies. The knowledge and skills deficit could be addressed through the development and implementation of a continuing professional development plan. The focus of the study was on the knowledge and skills of nurses who are directly involved with the rehabilitation of the mental health care users at the psychiatric rehabilitation centre. From the results of the evaluation that took place in the institution (Life Esidimeni 2008) the following question arose: "What knowledge and skills do nurses at the psychiatric rehabilitation centre need to implement appropriate rehabilitation strategies for mental health care users?"

1.3 RESEARCH PURPOSE

The purpose of the study was to gain an in-depth understanding of the knowledge and skills of nurses who work at a psychiatric rehabilitation centre for rehabilitation of mental health care users in order to design a continuing professional development plan for registered and enrolled nurses.

1.3.1 Research objectives

The objectives of this study were to

- explore and describe the knowledge and skills nurses have regarding rehabilitation of mental health care users
- develop a continuing professional development plan for nurses on rehabilitation in a psychiatric setting

1.4 SIGNIFICANCE OF THE STUDY

The findings of this study will guide the development of a continuing professional development plan for nurses involved in rehabilitation of mental health care users.

The implementation of the continuing professional development plan for nurses could contribute to the enhancement of rehabilitation at the psychiatric rehabilitation centre.

1.5 DEFINITION OF KEY CONCEPTS

- Continuing professional development (CPD): The means by which members of professions develop and maintain their capabilities in order to perform competently in the professional environment (Davids 2006:6). In this study, continuing professional development refers to the development of skills and knowledge needed for care, treatment and rehabilitation of mental health care users within a psychiatric setting.
- Rehabilitation: The process that assists an individual to achieve an optimal level of independent functioning (South Africa 2002:5). For the purpose of the study, rehabilitation is defined as the implementation of activities and tasks to maintain or improve a mental health care user's functioning level.
- Functioning level: In this context, it refers to the skills and abilities of mental health care users in each occupation performance area (De Witt 2005:12).
- Psychiatric rehabilitation centre: A health establishment for the care, treatment and rehabilitation of people with a psychiatric diagnosis on Axis 1 of the *Diagnostic and statistical manual of mental disorders* (South Africa 2002:5), which describes the total classification of psychiatric disorders (Pietersen & Middleton 2010:209).
- Mental health care user: A person receiving care, treatment and rehabilitation services or making use of a health service at a health establishment intended to enhance the mental health status of a user (South Africa 2005:5).
- Comprehensive approach: A broad scope or content, including all or most aspects (*Dictionary Reverso* 2000). A comprehensive approach in this study involves exploring and describing all aspects of the nurses' skills and knowledge concerning rehabilitation.
- Registered nurse: A person registered as a nurse or midwife in terms of the Nursing Act (Act No 33 of 2005) (R2598, 1984, Paragraph 1).
- Enrolled nurse: A person enrolled as a nurse in terms of the Nursing Act (Act No 33 of 2005) (R2598, 1984, Paragraph 1).
- Nurse: Registered and enrolled nurses will be referred to as nurses throughout this study.
- Knowledge: Facts and skills acquired through experience or education (Online Oxford Dictionary undated). For the purpose of the study, knowledge is defined

as the information known by nurses concerning rehabilitation of the mental health care users.

- Skills: Ability to do something well (Online Oxford Dictionary undated). For the purpose of the study, skills are defined as the ability of nurses to implement rehabilitation practices and activities.

1.6 RESEARCH METHODOLOGY

The research methodology will be discussed under research design and population.

1.6.1 Research design

The study was driven by qualitative methods with limited disruption of the natural setting of the phenomenon in the psychiatric environment. According to Tappen (2011:45), qualitative research is exploratory, seeks to find meaning and allows for probing, and this enables the participants to give their viewpoints and perspectives concerning their own knowledge and skills, as explained by Yin (2011:8).

Qualitative research allows for detailed descriptions of the attitudes and thoughts of the participants (Jha 2008:45). In qualitative research attention is paid to the insider's view, which is explored and data is reported in a literary style through using the words of the participants (Streubert Speziale & Carpenter 2011:22-23), in order to obtain an authentic insight into the participants' experiences and give meaning to them (Burns & Grove 2005:23). The study uncovered new insights and understanding about the knowledge and skills of nurses regarding rehabilitation in a psychiatric context. The participants were able to express their thoughts and experiences concerning knowledge and skills needed within a psychiatric rehabilitation centre.

1.6.2 Population

The population has particular properties that make it a well-defined set that meets the sampling criteria. A population can be generally defined and involve millions of people, or it can be narrowly specific and only include several hundred people (LoBiondo-Wood & Haber 2010:221, 222). The population for the study consisted of thirty-seven registered and enrolled nurses employed at the psychiatric rehabilitation centre who are

directly involved in the rehabilitation of the mental health care users. The sampling frame was obtained from the staff establishment list, which specified all the multi-disciplinary staff members employed at the psychiatric rehabilitation centre.

1.6.3 Selection of participants

All registered and enrolled nurses employed at the psychiatric rehabilitation centre who are directly involved in the rehabilitation of mental health care users and working day duty were invited to participate. Due to the manageable size of the population, no sampling took place and a census was done.

The population and sampling are described in detail in Chapter 2.

1.7 RESEARCH SETTING

The research setting was a psychiatric rehabilitation centre which has a public-private partnership with the Department of Health. The centre consists of 14 wards with 990 beds. The centre has 264 staff members, that include nurses, occupational therapy staff, physiotherapy staff, social workers, pharmacy staff, psychiatrists and physicians.

Involuntary and assisted mental health care users are admitted to the psychiatric rehabilitation centre, as discussed in the Mental Health Care Act (Act No 17 of 2002) (South Africa. 2002:24 & 26). Mental health care users admitted to the psychiatric rehabilitation centre are older than 18 years (Ure 2013:2).

1.8 DATA COLLECTION

Burns and Grove (2005:539) describe data collection as a precise and systematic gathering of information which is relevant to the research purpose, objectives and questions. Data collection (structured or unstructured) is a means to achieve the objectives and fulfil the purpose of the study. In this study, unstructured data collection was done. This method of data collection is appropriate for exploring the knowledge and skills of participants regarding rehabilitation within a psychiatric context, because it allows for deeper and more thoughtful responses (Polit & Beck 2008:372). The data

collection method used for this study was focus groups. The data collection and analysis are discussed in Chapters 2 and 3.

1.8.1 Data collection instrument

A central question was asked in the focus groups and probing questions followed for in-depth examination. The central question asked was "What knowledge and skills do you feel are important and needed in the psychiatric rehabilitation centre?" The discussion that followed after this question guided the researcher in asking probing questions to ensure that the focus of the discussion correlated with the objectives of the study.

1.8.2 Data analysis

Data analysis was done according to the steps explained by Streubert Speziale and Carpenter (2011:45-46). The data analysis will be discussed in detail in Chapter 3.

1.9 TRUSTWORTHINESS

Trustworthiness is the adherence to high standards in conducting research; it persuades readers that the findings reported in the study are worth paying attention to (Tappen 2011:153). According to Polit and Beck (2008:539), trustworthiness will be enhanced by credibility, transferability, dependability and confirmability of the data. Measures to enhance trustworthiness will be discussed in Chapter 2.

1.10 ETHICAL CONSIDERATIONS

Research requires not only expertise and diligence but also honesty and integrity in order for it to produce sound knowledge for practice; therefore it needs to be conducted in an ethical manner (Burns & Grove 2005:176). Ethical considerations must be taken into account in order for the researcher to make the correct choices and be accountable during the research process (Norwood 2010:69).

1.10.1 Protecting the rights of the participants

1.10.1.1 Informed consent

The rights of the participants have to be protected by recognising their autonomy (Orb, Eisenhauer & Wynaden 2001:94-95). Before consent was obtained, information was given to the participants about voluntary participation, the research method, risks and benefits, how the researcher would go into the environment where the research took place and what time commitments were expected of the participants. The researcher re-evaluated the participants' consent at different stages in the study to ensure their continued participation and understanding of the research process.

1.10.1.2 Confidentiality

Confidentiality is a pledge that any information provided by the participants will not be reported publicly in a way that makes them identifiable, and that this information will also not be accessible to others (Streubert Speziale & Carpenter 2011:60). Participants were assured that information provided would be reported in such a way that they would remain anonymous.

1.10.2 Rights of the institution

The rights of the institution were protected. Information about the purpose, scope of study and how the results would be used was given to the management of the centre before permission to conduct the study was obtained. Informed consent was obtained from the head of the health establishment, who was the Hospital Manager (see Annexure 4). Confidentiality was taken into account by the researcher. Management was informed that the participants would not be kept from their duties, in view of the regulation of the psychiatric rehabilitation centre that the participants put in a full day's work.

1.10.3 Scientific integrity of the researcher

The researcher is a psychiatric nurse skilled in interviewing processes. The researcher ensured scientific integrity by reading widely on the subject chosen for the study,

namely rehabilitation of mental health care users and continuing professional development of nurses. The report of the study avoided plagiarism because the books, journal articles and websites used during the research were cited as references. The supervisors of the researcher oversaw the study.

1.11 SCOPE AND LIMITATIONS

The scope of the study involved the setting in which it took place; this was one psychiatric rehabilitation centre. The nurses who were working in the wards and implemented rehabilitation for the mental health care users were involved in the study.

Limitations of the study included:

- The study was conducted in one psychiatric rehabilitation centre. A similar study in another psychiatric rehabilitation centre could result in different findings because the purpose of this study was not to generalise the findings.
- The nurses working night duty were not included in the study, even though they do work day shift at times and therefore need to implement rehabilitation during the day.

1.12 STRUCTURE OF THE DISSERTATION

Chapter 2 outlines the research design and methodology.

Chapter 3 presents the data analysis.

Chapter 4 gives a discussion of the findings and the literature that supports the findings.

Chapter 5 concludes the study, discusses its limitations, and makes recommendations for nursing education, nursing practice and further research, and a continuing development plan is devised.

1.13 CONCLUSION

This chapter served as an introduction to the study and discussed the problem to be researched, the purpose of the study and the significance of the study. The suitability of a qualitative approach to reaching the objectives of the study was explained. Relevant concepts were defined and the structure of the dissertation was outlined. Chapter 2 presents the research design and methodology.

CHAPTER 2

RESEARCH METHODOLOGY

2.1 INTRODUCTION

Research methodology involves the logic behind the research methods used during the study and explains why certain methods or techniques were used (Kumar 2008:5). The whole study is directed by the research methodology. It controls the study, dictates how the data is collected, arranges it in logical sequences, sets up a method for refining and synthesising the data, suggests a way in which the meanings of the data become known and finally yields conclusions that lead to growth of knowledge (Leedy & Ormrod 2010:6). This chapter presents the research design and methodology adopted in this study.

2.2 PURPOSE OF THE STUDY

The purpose of the study was to gain an in-depth understanding of the knowledge and skills regarding rehabilitation of mental health care users of nurses who work at a psychiatric rehabilitation centre, in order to design a continuing professional development plan.

2.3 RESEARCH DESIGN

A research design guides the researcher to plan and implement the study so that the purpose and objectives of the study are achieved (Burns & Grove 2005:211).The general layout of the study is guided by the research design, which identifies strategies the researcher will use in order to obtain accurate findings that in the end can make a meaningful contribution (Norwood 2010:186). This study used a qualitative exploratory descriptive design to explore the knowledge and skills regarding the rehabilitation of mental health care users of nurses who practise in a psychiatric rehabilitation centre.

2.3.1 Qualitative research

Qualitative research is an inquiry process which allows for the exploration of a social or human problem. The researcher builds a holistic picture, analyses the words spoken, reports detailed views of the participants and conducts the study in a natural setting (Tappen 2011:37). Data in qualitative research are reported in a literary style, with the participants' interpretations. Quotations, commentaries and narratives enrich the report (Streubert Speziale & Carpenter 2011:22-23). A qualitative design was chosen because it allowed participants to express themselves in their own voice, rather than selecting predetermined options in a questionnaire, thereby allowing the findings to reflect the understanding of the participants about rehabilitation in mental health care from their viewpoint. Qualitative research seeks meaning; this study uncovered the personal understanding and personal experiences the participants had of rehabilitation. Focus groups allowed for probing and clarification during data collection.

According to Saldana (2011:4), the outcomes of qualitative research usually involve the understanding of human meanings, and are made up of new insights and understandings of individuals and society. The researcher obtained insights into the way of thinking of the participants and thus a holistic picture of their understanding of the skills and knowledge needed for rehabilitation. This in turn allowed the researcher to design a continuing professional development plan for nurses on rehabilitation within the mental health care context. The knowledge and skills of the nurses concerning the process of rehabilitation and how effective it should be for the mental health care users emerged through the discussions and data collection.

The outcomes of qualitative data are described by Norwood (2010:49) as a narrative story rich and deep in truth which will enable the researcher (Tappen 2011:48) to understand the experiences in depth. Streubert Speziale and Carpenter (2011:22) advise that the researcher should build a trusting relationship and get rid of any distractions in order to gain the insider's view. In this study the researcher built a trusting relationship with the participants by giving them full information concerning the study and the benefits of the study, and by conducting the focus groups in a way that ensured confidentiality and anonymity and allowed expression of their own experiences and viewpoints without any judgement. This approach allowed the researcher to gain an

in-depth understanding of the views of the nurses regarding rehabilitation in a psychiatric environment.

2.3.2 Exploratory descriptive design

To explore means to study, examine and analyse an event or people, to become familiar with it or them through testing or investigating (Stebbins 2001:2). Exploratory research intends to gain a detailed picture of the participants' views through the eliciting of descriptions. Exploratory studies are useful to discover information about little-known phenomena when prior research is not known (Huttlinger 2012:168). Saldana (2011:29) states that description allows for the research questions to be answered through field work and presents a factual account of what is happening.

Little was known about nurses' knowledge and their understanding of psychiatric rehabilitation, even though this psychiatric rehabilitation centre places its focus on rehabilitation of mental health care users. Description allowed the participants to describe their understanding of rehabilitation, the knowledge and skills they felt were needed to implement rehabilitation, and to describe their own experiences of rehabilitation within a psychiatric setting.

2.4 RESEARCH METHODS

According to Kothari (2004:8), the research method refers to methods the researcher uses to implement research processes while studying the research problem.

2.4.1 Research setting

The research setting is an environment that is selected for a specific purpose in research (McBurney & White 2009:197). In this case conducting the research in a natural setting meant the study took place in a setting familiar to the participants. The research setting is a psychiatric rehabilitation centre with the focus on care, treatment and rehabilitation. The rehabilitation centre has 14 wards with a total of 990 beds. The staff establishment is made up of a multi-disciplinary team which includes nursing staff,

occupational therapy staff, physiotherapy staff, pharmacy staff, psychiatrists, physicians and social workers.

The psychiatric rehabilitation facility on the West Rand in Gauteng province was chosen because of the researcher's involvement as a clinical training specialist at the facility. The Life Healthcare group has five facilities in the psychiatric and rehabilitation section, named Life Esidimeni, in Gauteng.

2.4.2 Population

A population has particular properties that make it a well-defined set. A population can involve millions of people or it can include several hundred people (LoBiondo-Wood & Haber 2010:221-222).

The population for the study comprised 37 registered and enrolled nurses employed at the psychiatric rehabilitation centre who are, according to their role in the specific wards, directly involved in the rehabilitation of the mental health care users.

Eligibility criteria for inclusion in the study were:

- The participants had to be permanently employed registered and enrolled nurses working at the psychiatric rehabilitation centre.
- The nurses had to be directly involved in the rehabilitation of mental health care users in the respective wards.
- The nurses working day duty during the time of the study were to be included in the study

2.4.3 Sampling

Sampling is based on the reasoning that it is efficient and accurate to use information from a portion of a population to represent the whole population (Norwood 2010:220). According to Polit and Beck (2008:339), sampling is a process of selecting a portion of the population to represent the total population in order for interpretations to be made.

Due to the manageable size of the population, all registered and enrolled nurses who met the inclusion criteria were invited to participate; therefore no sampling took place.

2.5 DATA COLLECTION

Burns and Grove (2005:539) describe data collection as a precise and systematic gathering of information which is relevant to the research purpose, objectives and questions. An unstructured approach, using focus groups, was used to collect data from registered and enrolled nurses at the centre.

2.5.1 Focus groups

Focus groups are used to explore different topics in the clinical, educational and management areas within nursing (Streubert Speziale & Carpenter 2011:38). According to Stewart, Shamdasari and Rook (2007:40, 43) a focus group is very flexible, as it is unstructured and results from the focus group are user friendly and easy to understand. This method of data collection is appropriate for in-depth examination of what is being studied because discussion is promoted. The researcher was able to explore participants' understanding of their skills and knowledge in the rehabilitation of mental health care users. Focus groups are suited to qualitative data collection because they have the advantages of being inexpensive, flexible, motivating, assist in information recall and allow for rich data to be produced (Streubert Speziale & Carpenter 2011:37-38). Focus groups allowed the participants to share their views and experiences in a non-threatening and non-judgemental environment. Data collection in the focus groups continued until data saturation had been reached, when no new information was obtained from the participants.

Discussions in the focus groups were promoted through probing questions that enabled the researcher to uncover information shared by participants. It allowed participants to think critically about rehabilitation of the mental health care user.

The role of a qualitative researcher is to look beneath the content of "stories" or information given to uncover the functions that such storytelling or information accomplishes for participants, understand why people tell particular stories, or present their experiences in a certain way (Barbour 2007:34). The researcher probed and

clarified information given in order to understand certain experiences the participants described.

2.5.2 Preparing for the focus groups

Preparation for the focus groups started with compiling a list of the participants according to the wards where they worked and their shift allocations in order to contact them. The training room was selected as the venue because of its location and privacy. Refreshments such as juice and snacks were arranged in order to ensure a relaxed atmosphere. The information concerning the research and focus groups was discussed with the participants and an information leaflet was given to them (see Annexure 1). The study was discussed with seven (7) registered nurses and thirty (30) enrolled nurses on day duty.

The purpose of the study, the central question to be asked and their rights regarding participation in the study were explained. Consent forms (see Annexure 2) were given to the participants to read before signing. Six (6) registered nurses and twenty-seven (27) enrolled nurses signed consent forms and received invitations to the focus groups. Two of the focus groups comprised eight participants in each group, and the third focus group was to comprise nine participants, but one enrolled nurse did not participate in the focus group due to poor timekeeping. A fourth focus group was conducted in order to ensure data saturation had been reached; this group comprised four participants (eight had been invited to attend and signed consent but four withdrew from the study). Three focus groups included registered and enrolled nurses and one comprised only enrolled nurses. The researcher requested a colleague to be the co-facilitator for the focus groups. The co-facilitator was asked to make notes concerning the non-verbal communication of the participants, as well as in a summarised version what was being verbalised by the participants. A good-quality recorder with extra batteries was arranged, and stationery such as paper and pencils was organised for the co-facilitator, who was an experienced psychiatric nurse.

2.5.3 Facilitation of the focus groups

The participants and researcher were seated in a circle in full view of one another; the co-facilitator was seated in a position to observe the participants. A sign “Do not disturb,

meeting in progress" was placed on the door of the venue. The participants were each given a sticker with the word "speaker" on it together with a number; this was to ensure anonymity during the recordings of the focus groups.

The participants and co-facilitator were welcomed, thanked for participating and given the opportunity to introduce themselves to the group. The researcher explained to the participants the role the co-facilitator would play.

The following guidelines for the focus groups were discussed: all cell phones were to be turned off and only one person at a time should speak. Confidentiality was emphasised, nobody would leave the venue and discuss what was said during the focus groups: this included the co-facilitator and researcher. The participants were made aware that they could withdraw at any stage and would not be pressurised to stay, thereby re-evaluating their consent to participate. The participants were informed again that the focus group would be recorded. The researcher briefly explained the purpose of the research, as had been explained when the information leaflets were discussed. Time was given for any questions the participants might have had.

The researcher commenced the focus groups with the central question "What knowledge and skills do you feel are important and needed in the psychiatric rehabilitation centre?" Further open-ended questions were asked in order to clarify statements made, and probing took place in order to gain further information from the participants.

The first focus group was a pilot focus group in order to assess any problems or issues that needed attention before commencing with the other focus groups. The only minor problem that occurred was that the recorder was situated too far from some of the participants, so the recording of their voices was a little soft. This was corrected for the next focus groups and the recorder was placed in the middle of the group.

2.6 DATA ANALYSIS

Qualitative data analysis is a set of processes that enables the researcher to collect a large amount of in-depth information or data on a smaller sample (Lyons & Doueck

2010:132). It explores the ways in which these patterns and categories interact, and how the categories may influence or affect the others (Saldana 2011:92).

The data analysis steps recommended by Streubert Speziale and Carpenter (2011:45) were followed for the study and are discussed in Chapter 3.

2.7 TRUSTWORTHINESS

Trustworthiness in qualitative research means that rigour is maintained; this is shown through the researcher's consideration and confirmation of the discovery of information. The goal of rigour is to accurately represent the participants' experiences or information shared (Streubert Speziale & Carpenter 2011:48).

The following criteria were followed to ensure trustworthiness: credibility, transferability, dependability and confirmability.

Table 2.1 Trustworthiness in qualitative research

Criteria for trustworthiness	**Current research study**
Credibility: Credibility, according to Polit and Beck (2008:539), is confidence in the truth of the data collected and the interpretation of the data.	Credibility was established through continually engaging with the subject matter and considering whether participants recognised the findings of the study to be true. One participant from each focus group read the transcripts from that particular focus group to confirm that they were a true reflection of what had been described. A co-coder read the transcripts and listened to the recordings to compare the data analysis of the researcher (see Annexure 7). The credibility of the study was enhanced through continuing data collection until data saturation had been attained. The researcher increased interactions with the nurses, remaining in the field of study until no further information was obtained.

Criteria for trustworthiness	Current research study
	The preliminary findings were given to the participants and feedback was received from the participants verbally and in writing. They stated that the findings were a true reflection of the data collected during the focus groups. The researcher is a qualified registered nurse and a qualified psychiatric nurse with the South African Nursing Council (SANC) and skilled in interviewing, has experience in the field of education and training of nursing staff within a psychiatric rehabilitation centre.
Transferability: this is the probability that the study findings will have meaning for other people in similar situations. Determining whether the findings are transferable rests with those who might use the findings, and not with the researcher (Streubert Speziale & Carpenter 2011:49). According to Tappen (2011:160), a detailed description of the study sample and context in which the study takes place enables others to decide the extent to which the findings can be transferred to other situations or individuals.	Gaining understanding of the nurses' knowledge and skills concerning rehabilitation allowed for the development of a continuing professional development plan for the nurses at the psychiatric rehabilitation centre where the research was done. The plan could be implemented at other psychiatric rehabilitation centres.
Dependability: is the stability or reliability of data over time and over conditions.	The following question was asked to ensure dependability: "Would the findings of the study be the same if the study was repeated with the same or similar participants and in the same or similar situation?"
Confirmability: is concerned with establishing that the data represent the information provided by the participants and that the interpretation of the data is not the imagination of the researcher; therefore the findings must reflect the participants' voice and perceptions (Polit & Beck 2008:539).	An audit trail was created during the study through carefully compiled records of the conducting of the study, the thoughts of the researcher and the decisions made. Raw data were compiled and this included field notes and recordings made during the focus groups. Summaries made and themes, sub-themes and categories developed during data analysis formed part of the audit trail. The audit trail provided transparency and it ensured that the researcher remained disciplined throughout the research process. Notes taken during the focus groups were reviewed and the recordings were listened to ensured confirmability.

2.8 ETHICAL CONSIDERATIONS

The subject of ethics deals with morality, goodness and rightness of human behaviour (Norwood 2010:69). Ethics relate to obligations, rights, duty, justice, choice, intention and responsibility (Burns & Grove 2005:62).

In this study the researcher observed the following ethical considerations.

2.8.1 Permission to conduct the study

The researcher obtained ethical approval for the study from the Higher Degrees Committee, Department of Health Studies, Unisa, prior to doing the research (see Annexure 6). Permission to do the research was obtained from the hospital manager of the psychiatric rehabilitation centre and from the Nursing Research Committee of the College Senate of the company of which the psychiatric rehabilitation centre is a part (see Annexure 5).

2.8.2 Ethical principles

The following ethical principles were adhered to:

2.8.2.1 Principle of beneficence

This principle relates to the benefit that research would have for those participating. The researcher followed the principle of beneficence, which has multiple dimensions including freedom from harm, freedom from exploitation and balance between the risk/benefit ratio. The findings of this study would be used to develop a continuing professional development plan for nurses practising within a psychiatric discipline.

2.8.2.2 Principle of justice

Participants were treated fairly and with respect and recognised as important resources of information needed for the study. Confidentiality forms part of the principle of justice. Confidentiality is the researcher's management of private information which the participant shares; this information must not be shared with others without the consent

of the participant (Burns & Grove 2005:188). Confidentiality was maintained through the removal of any identifiable information once the focus groups had been verified and the researcher was certain no further information was needed from the participants. The researcher ensured that examples of raw data would not reveal the identity of the participants in the process of publication of the research. Raw data will be kept for at least five years after the completion of the study. The recordings made during data collection were stored in a safe place and the findings were reported in a way that ensured anonymity of the participants.

2.8.2.3 Principle of autonomy

The principle of autonomy was followed by obtaining informed consent from the participants. Participants were given an information brochure with information about the study (see Annexure 1), including the option to participate in or withdraw from the study.

2.9 CONCLUSION

Chapter 2 described the research design and methodology. The population, sampling, data collection and data analysis were discussed. The measures taken to ensure trustworthiness and ethical considerations of the study were presented. Chapter 3 presents the data analysis, together with verbatim quotations from the participants.

CHAPTER 3

PRESENTATION OF THE DATA

3.1 INTRODUCTION

This chapter discusses the analysis of data obtained from the focus groups that were conducted with nurses who worked at a psychiatric rehabilitation centre in Randfontein, Gauteng province. Data analysis organises, provides structure to and obtains meaning from the research data collected; it needs to be concise yet must not lose the richness of the data (Polit & Beck 2008:507), which means the data that emerged from the descriptions given by the participants must be reported exactly as described, which in turn allows the richness of the data to emerge. The objectives of the study were to explore and describe the knowledge and skills nurses in a psychiatric rehabilitation setting have regarding rehabilitation of mental health care users, in order to develop a continuing professional development plan for nurses working in the centre.

Four focus groups were conducted: three with eight participants in each group and one focus group with four participants. The data are presented in a discussion of the themes, sub-themes and categories, with verbatim supporting statements as they emerged during the focus groups.

3.2 DATA ANALYSIS

Once the focus groups had been completed, the recordings were listened to and verbatim statements made by the participants were transcribed. The non-verbal communication portrayed during the focus groups was written down by the co-facilitator and taken note of by the researcher while reading the transcripts. The researcher started the discussion in the focus groups by introducing herself and then posed the central question "What knowledge and skills do you feel are important and needed in the psychiatric rehabilitation centre?"

The data analysis steps described in Streubert Speziale and Carpenter (2011:45-46) were used to analyse the data. The researcher intently studied the recordings, the transcribed notes she had taken after listening to the recordings and the field notes taken by the co-facilitator during the focus groups. The researcher immersed herself in the data to identify and write down meaningful statements, relevant to the purpose and objectives of the study, expressed by the participants during the focus groups. The researcher, engaging with the data, took note of, and wrote down on flipchart paper new insights and understandings as expressed by the participants. The quotes of the participants, together with the central question and probing questions, were also written on flipchart paper. Individual words and phrases taken from these quotes were written on separate flipchart pages to form units which assisted in the deduction of categories from the verbatim quotes. Coloured pens were used to cluster similar data from the units, which led to the identification of categories, sub-themes and themes as they emerged from the data.

3.2.1 Biographical detail

The biographical data reflect participants' gender, category of nurse and experience since qualifying in that nursing category.

Table 3.1 provides the combined biographic data that describe the specific attributes of the participants.

Table 3.1 Biographical information

	Focus group 1 (n=8)	**Focus group 2 (n=8)**	**Focus group 3 (n=8)**	**Focus group 4 (n=4)**
Gender	Males – 2 Females – 6	Males – 1 Females – 7	Males – 0 Females – 8	Males – 2 Females – 2
Category of nurse	Registered Nurse – 2 Enrolled Nurse – 6	Registered Nurse – 3 Enrolled Nurse – 5	Registered Nurse – 1 Enrolled Nurse – 7	Registered Nurse – 0 Enrolled Nurse – 4
Experience since qualifying in that nursing category	0–5 years=3 5–10 years=4 10–20 years=0 20–30 years=0 30–40 years=1	0–5 years=3 5–10 years=3 10–20 years=1 20–30 years=0 30–40 years=1	0–5 years=4 5–10 years=3 10–20 years=1 20–30 years=0 30–40 years=0	0–5 years= 3 5–10 years=0 10–20 years=0 20–30 years=1 30–40 years=0

A total of 28 nurses, of whom five were males and 23 were females, participated in the focus groups. Six registered nurses and 22 enrolled nurses participated. The number of

enrolled nurses employed at the psychiatric rehabilitation centre far outweighs the number of registered nurses employed at the centre. The staff establishment at the psychiatric rehabilitation centre comprises 10 registered nurses and 36 enrolled nurses (Life Esidimeni 2013). As the table shows, 13 participants had 0 to 5 years' experience within their nursing category; ten had between 5 and10 years; two between 10 and 20 years; one between 20 and 30 years and two between 30 and 40 years. Out of 28 participants, 23 had 10 years' or less experience, while only five had more than 10 years' experience.

3.3 THEMES

Four themes with associated categories emerged from the data collected during the three focus groups. These were:

Theme 1: Knowledge of the rehabilitation process
Theme 2: The need for continuing professional development
Theme 3: Nursing skills required for the implementation of psychiatric rehabilitation
Theme 4: Means of communication within psychiatric rehabilitation

Theme 1: Knowledge of the rehabilitation process

In Theme 1, knowledge of the rehabilitation process, nine sub-themes emerged: the meaning of rehabilitation; assessment of the mental health care users' functioning; planning of rehabilitation; implementation of activities; implementation of education; evaluation of care users' response to rehabilitation; multi-disciplinary team; management of mental disorders and signs and symptoms thereof; and therapeutic relationship with mental health care users within the rehabilitation process. The sub-themes and categories in Theme 1 are presented in Table 3.2.

Table 3.2 Theme 1: Knowledge of the rehabilitation process

Theme	Sub-theme	Category
Theme 1: Knowledge of the rehabilitation process	The meaning of rehabilitation	• Returning to and functioning independently in the community • Changing of lives • Handling of people
	Assessment of the mental health care user's functioning	• Determine level of functioning • Rehabilitation activities • Information obtained on assessment
	Planning of rehabilitation	• Planning according to problems identified • Planning of individual rehabilitation
	Implementation of activities	• Specific group activities • Activities according to level of functioning • Activities of daily living • Activities for discharge
	Implementation of education	• Education of mental health care user • Education of family members
	Evaluation of care users' response to rehabilitation	• Reasons for evaluation • What evaluation entails
	Multi-disciplinary team	• The role of the multi-disciplinary team
	Management of mental disorders	• Management of signs and symptoms • Management of specific mental disorders
	Therapeutic relationship with mental health care users within the rehabilitation process	• Nurse-patient relationship • Importance of knowing the mental health care user • Acknowledgement that mental health care users should be treated with respect and dignity • Understanding cultural and religious beliefs

3.3.1 The meaning of rehabilitation

Probing questions were asked to gain an understanding of the participants' views on rehabilitation. The following data were collected in response to the question "What do you understand rehabilitation to be?" In the sub-theme "The meaning of rehabilitation", participants described their views on rehabilitation in terms of the value that rehabilitation could add to mental health care users' lives and well-being. Three categories emerged from the data: namely *returning to and functioning independently in the community, changing of lives and handling of people.* Literature that refers to the sub-theme states that psychiatric rehabilitation is defined as a therapeutic approach that allows a mentally ill person to develop to his or her fullest capabilities through learning and support (Corrigan et al 2008:50).

Category 1: Returning to and functioning independently in the community

The participants' responses to the question on what rehabilitation is, focused on the mental health care users' ability to return to the community and to function at their own optimal level of independence within the community. They described their role in enabling the care user to return to the community and to be able to function at their optimal level. The following verbatim quotes support this finding:

> "... You are trying to incorporate this individual back into the community, so by, by having these skills you will be able to see where can you assist this particular person so that you can bring him back to the community being a better person who is able to deal with the social stress that are outside."

> "What I had learnt is that all of us here have one goal and our goal is to see that our patients are back to the community functioning normally, ... we want to see them outside, greeting saying "Staff I am driving my own car, working, I am married, I've got a house."

Category 2: Changing of lives

Participants described rehabilitation as changing of the lives of mental health care users – physically, mentally and in the way that they think. The professional behaviour of the nurses also results in changing of the lives of the users through the professional example they set. Verbatim statements made by the participants are given below:

> "... we are more involved in patients' rehabilitation or patients' education in many ways and it is a must, they, we are fully committed because we want to change peoples' lives, … the most thing that we need is that change: we need patients to change in many ways that they change mentally, physically."

> "... how you present yourself by, aah, wearing uniform means something to another patient, because he is learning something that you know, if, even if, aah, the person wearing a uniform, which means he is part of this rehabilitation ... where we want to change other peoples, in the way people think, the way they think and mostly is what we are doing here."

Category 3: Handling of people

Participants explained that rehabilitation is about the way people, including the mental health care users, are treated and handled by the staff at the psychiatric rehabilitation centre. They mentioned that mental health care users should be treated equally and with respect because they were still human beings. This is indicated in the quotations from the participants:

> "… when you come early in the morning, where you have a plan for the day, rehabilitation starts, now when you come in, you greet those people, the patients, is part of rehabilitation because he knows that a good manner should greet."

> "… you want to be respected, so why can't you respect other people, to treat them equally."

3.3.2 Assessment of the mental health care users' functioning

In the sub-theme "Assessment of the mental health care users' functioning", participants described the reasons for performing an assessment. Three categories emerged from the data: *determining the level of functioning, rehabilitation activities* and *information obtained on assessment.*

Participants explained that assessment is the first step in the rehabilitation process.

Uys (2010c:188) indicates that the rehabilitation process commences when the nurse begins with the assessment of the patient or group, followed by planning of the care and then implementation of the plan. Evaluation takes place throughout the process.

Category 1: Determining the level of functioning

Participants stated that the level of functioning of mental health care users at the psychiatric rehabilitation centre differs and that assessment allows the nurses to determine their level of functioning in order to implement the appropriate rehabilitation programme. Through assessment they determine whether the care users are functioning at a low level or a higher level. The following verbatim quotes support this:

> "Firstly assess, you assess the patient, before rehabilitating them, you assess by going to her or him, maybe the other one is too low or the other one is too high, I … assess according to their level of function."

> "You will be able to see [the] level of functioning of the patient and the IQ, so that when you do activities you don't involve her in activities not at that level."

> "… mostly we do have different levels in the ward where now, aah, not different levels that we put in a group … mainly activities that are in the ward they are specifically for the levels of functioning of patients."

Category 2: Rehabilitation activities

Participants explained that after assessment they will be able to implement certain activities and obtain additional assessment information through the group activities, which ensure rehabilitation takes place on a specific user's level of functioning. The following statements support this category:

> "Okay, say for example you assess the patient, find this patient (is) not capable to maybe take care of personal hygiene, you know how to go about it with that patient when you are in the bathrooms …."

> "(laughs) But sometimes it happens whereby when you admit them you won't get the right information but when you are busy doing the group activities that's whereby you are going to pick it up …."

Category 3: Information obtained on assessment

Participants described the information that they obtained on assessment. This included information given verbally by patients concerning their history, orientation to time, place and person and their insight into their mental illness. Information is also obtained through assessment of mental health care users' abilities and skills. The verbatim quotes that follow indicate the data that emerged from this discussion.

> “Sometimes by asking the person about their history, ask them what they like the most, maybe what they used to like the most … then you ask about their history.”

> “Um, when asking, when interviewing first thing I ask him is about his orientation, sometimes the patient who don’t even know where they are, there (are) some who remember but there (are) some, they are long here but they can’t even remember. We ask about their insight. Why are they here? ....”

> “And during observation, if it is a certain time for a certain procedure you see who needs to be reminded of how to do it ….”

3.3.3 Planning of rehabilitation

In the sub-theme “Planning of rehabilitation*”,* participants described different planning that has to be done in order for rehabilitation of mental health care users to take place. Two categories emerged from the data: *planning according to problems identified* and *planning of individual rehabilitation.*

Planning was identified as the second step in the rehabilitation process. According to Neeraja (2008:45), the nurse evaluates the nursing care implemented by assessing the response and progress of the mental health care user, then revises the nursing diagnosis and plans the nursing interventions accordingly.

Category 1: Plan according to problems identified

Participants described how problems are identified in order to plan the rehabilitation of mental health care users. They described what they specifically plan to do or implement once the problem for that particular individual has been identified.

> “My involvement with patients … identifying the problem, refer to MDT (Multi-disciplinary team) if the problem is above your scope, by referring him to social worker… different parts of the MDT. Treat the patient, plan for the patient and then you can also do a care plan for the patient.”

> “No, I won’t record the same thing ... and so I am going to take a new, new like new problem and identify it ... A person who reads my Cardex will see that one

> was like maybe resolved or you know how can I put it, but it is no longer in place, putting another problem."

Category 2: Planning of individual rehabilitation

The participants emphasised the importance of individual rehabilitation and the planning that is needed for it to be implemented, which involves asking questions of the patients about their behaviour and communicating with them. Implementation according to individual needs cannot take place unless planning for those needs has occurred. The following quotations support this category:

> "… once you see a relapse, the first thing that comes to mind is, is this patient swallowing his medication? Is the supervision done correctly ... because he didn't swallow that because he knows "Ah ha, [Participants' name] going to give us medication and so won't check if I swallow them or not", that is when he starts relapsing, but you know once that happens you start planning: 'How am I going to deal with this case?' ..."

> "... when we communicate with the patient we should understand what kind of things that he enjoy(s) mostly is where we can make a plan ...."

3.3.4 Implementation of activities

In the sub-theme "Implementation of activities", participants described different activities they need to implement in order for rehabilitation to take place. Four categories emerged from the data: s*pecific group activities, activities according to level of functioning, activities of daily living and activities for discharge.*

Nursing actions are identified and implemented to assist the patient in meeting the planned goals. The implemented nursing actions may include counselling, milieu therapy, self-care activities, administration of medication, health education and health promotion (Ballard 2008:27). Structured activities make up activity groups, and interaction between the members is developed in these groups; therefore the group needs to be therapeutic by ensuring progress occurs, problems are shared, group cohesion occurs and learning and socialisation takes place (Uys 2010b:248).

The following quotations describe the rehabilitation activities that participants implemented at the psychiatric rehabilitation centre.

Category 1: Specific group activities

Some of the participants provided information about specific group activities that they facilitated, whereas others stated they did not have time for these specific group activities. Groups that had been implemented by the nurses included discussion groups on issues the care users have or on their behaviour and health education groups. The quotations indicate that certain nurses implement group activities whereas others do not involve themselves in group activities.

> "I don't know if I can call it an activity or it's group discussion, like I've got a group of patients like six, then maybe I check what they do which is wrong, commonly wrong, like others who take too much snuff, so that one, I don't know. Does it fall there or not? Where we will have this session talk and tell about the advantages and disadvantages of what they are doing ...."

> "We are so much involved in doing this, you have a specific group for example, I'll be having a group on health education about smoking, you know whereby I would have sessions with them once a week and then we discuss and then listen to the improvement, commitments."

> "Because I am working with very low functioning users, usually what I do, I go there and on their group activity and only go there and observe what is going on and if there is somebody who does not participate I then ask or after the activity I tell the nurse that I wonder why that one is not participating … but personally I don't participate physically."

Category 2: Activities according to level of functioning

Participants described how and why activities were selected according to the level of functioning of a mental health care user. Participants distinguished between activities for high-functioning users and low-functioning users and what these activities involved. The activities for low-functioning care users, according to the participants, are building puzzles and sensory stimulation. Health education and climate meetings are activities

selected and implemented for the high-level functioning care user. This category is illustrated by the following quotes:

> "…You must group the one type in the same group, so that they can all participate because if they are different in (the) same group it won't be easy for them."

> "In our ward we've got low functioning levels, give them puzzles to put (together) animal puzzles …."

> "Sensory stimulation, mm ..., especially with the blinds. Sensory stimulation is e.g. is fun-lacing, ahh, like sometimes, ahh, sometimes you make the patient touch the lace or do the massage, sort of sensory stimulation."

> "Maybe if you engage them more often in climate meetings, in health education that's where you get a lot of information from them and that's how you communicate with them."

Category 3: Activities of daily living

The activities of daily living take place on a daily basis and users are involved in these activities either independently or with assistance from staff at the rehabilitation centre or family members at home. These activities, according to the participants, are implemented according to the level of functioning of the user, as supported by the quotations below:

> "Also the family must take the patient work to do, they mustn't just leave them, they must tell them to do their beds, wash the dishes, they must work at home."

> "... you can give them [the] toothbrush and then say "Go and do your oral hygiene" but when you look at them you could see that some of them don't even know if the toothbrush will go into the mouth or what [is] happening, how to do the procedure then that's imperative to focus mostly on to remind him how to do his oral hygiene."

Category 4: Activities for discharge

The participants described activities they implement to prepare mental health care users for discharge once rehabilitation has taken place and they have reached the highest acceptable level of functioning at the psychiatric rehabilitation centre. The activities allow them to be a part of the community and be accepted by the community, as stated below:

"We are preparing them to fit into the community so that when they are being discharged they can live the same life that is acceptable in the community. They mustn't feel that they are not the same as other people, that is why we have to teach them how to cook, teach them how to sweep the floor, teach them how to do gardening and all those things, that is why we say we are rehabilitating them."

3.3.5 Implementation of education

In the sub-theme "Implementation of education*",* participants described the type of education that is given to mental health care users and their families to facilitate rehabilitation. Two categories emerged from the data: e*ducation of the mental health care users* and *education of the family members.*

Literature related to the sub-theme states that nurses know the needs of the mental health care users through their illness and treatment plan, and teaching allows the nurse to clarify health information to the care user and family members (Neeraja 2008:69).

Category 1: Education of the mental health care users

Participants were asked probing questions concerning implementation of rehabilitation, specifically focusing on education of the mental health care users. It emerged that users are given information about the importance of the prescribed medication, substance abuse and their mental illness, as stated below:

> "The patient must know his medication and know he must take it at the right time, if he is at home, if the medication is finished then he must go to the clinic, not

alone because maybe he will never even, mm, reach the clinic, he must go with somebody, the family to fetch treatment and the family must make sure that the patient is drinking his medication."

"The important thing is to tell them that they must not use drugs when they're discharged, and alcohol."

"Educate them … you can give them knowledge about maybe their, even, their mental illness."

Category 2: Education of the family members

The need to educate family members was emphasised by participants. Family members were taught about the family member's specific mental illness or condition, the behaviour they might expect and the resources within the community. Education of family members helps them to cope when the care user goes home, either for Leave of Absence (LOA), or is discharged. The following verbatim quotations support this finding:

"… when educating the family, they must be aware that these people are still human beings, the language they speak to them and they must be made aware that at least the patient can function up to this far ... we should keep on educating, educating."

"It is very important for us to educate the family about care users which are their relatives, because first of all when they brought them here, they did not understand what was happening … so it is very important for us to tell them how we have rehabilitated the family members."

"..., also to continue giving health education to parents maybe to involve to let them involve the patients in the groups that are involved in the location maybe there are self-help groups or other group that has similar problems."

3.3.6 Evaluation of care users' response to rehabilitation

In the sub-theme "Evaluation of care users' response to rehabilitation", participants described reasons for evaluation and what is included when evaluation takes place in order for the nurses to gain information on the mental health care users' rehabilitation

progress. Two categories emerged from the data: r*easons for evaluation* and *what evaluation entails.*

According to Schultz and Videbeck (2009:230), evaluation is an ongoing activity included in the whole process in order to evaluate and revise the other steps of the process.

Category 1: Reasons for evaluation

Participants explained that they evaluated the mental health care user and took note of any progress or changes that had taken place through rehabilitation. The progress enabled the nurse to acknowledge that the appropriate rehabilitation was being implemented. This category is illustrated by the following quotation:

> "Because it's whereby you can see that your patient is progressing, like there is some changes, like remember if your patient last month was bad [pause], he or she was unable to do one, two, three, but when you are doing your monthly report this time this month that is whereby you are going to check ... that is whereby you are going to be able to say, okay, my patient last month was doing this but at least this month she was able at least to sit for a while in a group activity."

Category 2: What evaluation entails

This category presents information on what exactly is evaluated concerning the rehabilitation progress of mental health care users, including various problems they have had and their response to activities. Questioning takes place in order to obtain the evaluation information, as depicted in the quotations given below:

> "… activities that are being put in place in hospital should have aims and objectives; they should have the results after that. How did the patient respond on individual activities? Do they understand? Do they enjoy it? You know, because if they do enjoy it, I mean then we can stick to it, it's a good thing anyway."

> "I don't know but I think you are not supposed to write like one problem for six months, so if a patient [does] not know the time and place and then maybe it's a social [problem], you can't write for these two problems for six months."

3.3.7 Multi-disciplinary team

In the sub-theme "Multi-disciplinary team", participants described the role of the multi-disciplinary team in the rehabilitation process, including the specific role of certain team members. One category emerged from the data: *the role of the multi-disciplinary team in rehabilitation.*

The literature states that the ability to make a prompt and comprehensive assessment of a patient, as well as providing treatment in an in-patient setting, requires an interrelated team of health professionals who have comprehensive skills in assessing and treating mental disorders in an environment that is safe and therapeutic (Barry 2002:25).

Category 1: The role of the multi-disciplinary team in rehabilitation

The role of the multi-disciplinary team in the rehabilitation process and specific multi-disciplinary team members' roles within the psychiatric rehabilitation centre were highlighted. This category is illustrated by the following quotations:

> "Since you are dealing, err, with different patients and cultures, I think the MDT is important and our patients need improvement; maybe the patient is not responding to activity because she is having a problem and also to social work, so it is important."

> "… I would say I'll focus on my patient ... maybe I talk to the doctor and then discuss about that patient; maybe I consult my, my OT [Occupational therapy] personnel and stuff like that and maybe also to, to, err, maybe present the patient in MDT meeting so that we can get the progress of the patient."

> "Involve [the] social worker to probably arrange for NGO [Non-governmental organisation] ...."

3.3.8 Management of mental disorders

In the sub-theme "Management of mental disorders and signs and symptoms thereof*",* participants described the knowledge they had concerning the management of mental illness. Two categories emerged from the data: *management of the signs and symptoms of mental illness* and *management of specific mental disorders.*

Category 1: Management of the signs and symptoms of mental illness

Participants described the knowledge they had of the signs and symptoms displayed by care users, as well as the management of the care users who present with these signs and symptoms, which in turn helps the nurses to implement the appropriate rehabilitation. The statements below indicate the knowledge that the participants had:

> "I think knowledge about the patients' diseases… knowledge regarding maybe when they become disturbed ... to be able to see the signs and symptoms."

> "… our patients are very manipulative, aggressive besides with those ones that are low functioning … how you should handle like different types of patients that we have."

Category 2: Management of specific mental disorders

The participants discussed the knowledge they had about the management of specific mental illnesses or disorders that were presented by the care users at the rehabilitation centre; this knowledge allowed them to address any issues or behaviour specific to that illness or disorder. The category is illustrated by the following quotations:

> "Another thing, if they break a window, you must address the problem immediately because they [are] intellectually disabled … Immediately when he does wrong, you must address it immediately, then he will understand what you are trying to tell him."

> "Schizophrenia, I know what it is, with the problem, so that I do not get surprised with the signs and symptoms that the patient presents with."

3.3.9 Therapeutic relationship with mental health care users within the rehabilitation process

In the sub-theme "Therapeutic relationship with mental health care users within the rehabilitation process", participants described the therapeutic relationship they had with the mental health care users. Four categories emerged from the data: *Nurse-patient relationship, importance of knowing the mental health care user, acknowledgement that mental health care users are human beings who should be treated with respect and dignity* and *understanding cultural and religious beliefs.*

Category 1: Nurse-patient relationship

The nurse-patient relationship was described as a trusting relationship with the care user at the centre. The caring relationship between the nurse and care user was also emphasised by the participants. The statements made by the participants show that they understand that the nurse-patient relationship is important for rehabilitation to take place. This category is illustrated by the following quotations:

> "A psychiatric patient trust(s) the nursing staff in that institution ... The psychiatric patients, they don't usually listen to the nursing staff who are working in the TB side ... He didn't listen to them that is why it is important that nurse-patient relationship to be built and if the patient doesn't know you, he's not going to listen to you."

> "… we should also support our patients, we are the most people that knows their problem more than sometimes even at home, they don't talk to them the way they talk to us …."

> "You won't be able to get any information, from the patient if he doesn't trust you."

Category 2: Importance of knowing the mental health care user

Participants understood the importance of knowing the personal circumstances and background of the mental health care users in their care. This awareness is very important in the planning and implementation of individual rehabilitation. The following quotation represents the participants' views:

> "It is very important for us to know our patients for that will give us a way through that will give us understanding of what we have to do for the patient because you cannot implement something on the patient that you don't know."

Category 3: Acknowledgement that mental health care users should be treated with respect and dignity

The participants expressed awareness that mental health care users were human beings who must be treated with respect and dignity. The importance of the care users' understanding that they are human beings was also emphasised by the participants; this in turn improves self-esteem, which is necessary for rehabilitation to take place. This category is illustrated by the following quotations:

> "Another important thing, I think, is to teach the patient that she is human, she must just accept what is happening, even, just make example, like any other persons, that people are taking treatment for that and then that would boost her ...."

> "That is very good because we have to treat our patients with dignity so they are still human beings no matter how mentally ill they can be ...."

Category 4: *Understanding cultural and religious beliefs*

The participants described the importance of understanding and gaining information on the religious and cultural beliefs of the users in order to implement the relevant rehabilitation programme. Respecting their beliefs builds the therapeutic relationship between nurse and care user. The following quotes illustrate the nurses' understanding:

> "… knowing and respecting their cultures and beliefs so that you are not going to force a person to do a thing that is not done in his or her culture."

> "On admission I think there is an information there which tells you about the culture and belief or if is not there you can ask the patient if the patient doesn't give the right thing there is the family to ask."

> "I think also religion; I think it is also important ...."

Theme 2: The need for continuing professional development

In Theme 2, the need for continuing professional development, one sub-theme emerged: the need for further knowledge. The sub-theme and categories in Theme 2 are presented in Table 3.3.

Table 3.3 Theme 2: The need for continuing professional development

Theme	**Sub-theme**	**Category**
Theme 2 The need for continuing professional development	The need for further knowledge	• Knowledge regarding behaviour portrayed by people who suffer from specific mental conditions • Management of mental illness • Substance abuse by mental health care users • Specific rehabilitation activities • Management of low-level functioning mental health care users • Safety of staff members

3.3.10 The need for further knowledge

In the sub-theme "The need for further knowledge", participants described their need to obtain knowledge in specific areas in order to implement rehabilitation. Six categories emerged from the data: *knowledge about behaviour shown by people who suffer from specific mental conditions; management of mental illnesses; substance abuse by mental health care users; specific rehabilitation activities; management of low level functioning mental health care users; and safety of staff members.*

O'Carroll and Park (2007:9) state that knowledge is the foundation of effective practice.

The following probing question was asked: "What knowledge do you still want to gain concerning rehabilitation?" Information about specific needs will be used to design a continuing professional development plan.

Category 1: Knowledge about behaviour shown by people who suffer from specific mental conditions

Participants stated that they wanted to learn more about different mental illnesses and the behaviour shown by the mental health care users who have been diagnosed with these illnesses or conditions. Having this knowledge would allow the nurses to manage the care users appropriately. The following verbatim quotes illustrate the finding:

> "Maybe those people with intellectual disability, to know more about them, handling of intellectually disabled, low level, difficult to communicate with them."

> "I think also we, let's go back to the conditions, the psychiatric conditions of the patients, you know at times, err, we nurse by experience [laughs], more than you know even that deep, deep knowledge because that is going also to help people a lot …."

> "Bipolars [Bipolar Mood Disorder], you never know when they are going to snap ... so learn such behaviours, patterns."

Category 2: Management of mental illnesses

The participants claimed that they needed more knowledge on the management of different mental illnesses in order to care for, treat and rehabilitate the mental health care users. One participant stated that although they read books on how people who suffer from specific mental disorders may present themselves, they still needed more knowledge on the actual management of the mental illnesses. The appropriate management and handling would allow rehabilitation to take place.

> "What I would like to know, more and more about the skills, is how to handle them better ... I can learn more on how to care for them, even in that state they are, having more knowledge on it ... I even take books that are mental health books that [I am] trying to read more about even the conditions that they have."

> "… different types of the psychiatric conditions ... to know how to handle the psych patient."

Category 3: Substance abuse by mental health care users

Participants stated that they needed more knowledge about drug and substance abuse, as well as the handling of these mental health care users who presented with different addictions at the psychiatric rehabilitation centre. The following verbatim quotations support this finding:

> "Ahh, our patients like snuff too much, they are very addicted to that. I just want to know what can we substitute snuff with, they are very, very addicted, in a way that if they don't get the snuff they become so aggressive and angry."

> "… they realise "I was here, using cannabis from 18 years, now I am 30 years ...."

Category 4: Specific rehabilitation activities

Participants expressed the need for more knowledge on specific rehabilitation activities that took place at the occupational therapy department. The nurses believed that with this improved knowledge they would be able to assist the care users in their rehabilitation. The following quotations represent the views expressed:

> "Luckily we have our OT [Occupational therapy] staff who teaches them how to cook, though we [are] also with them, but I think it can be good if some of the nurses can be taught how to do different skills like mending of shoes, cooking, yes we know how to cook but we have to know how to teach them to cook, for, because most of the things we depend on the OT staff ...."

> "Yes, like candle making, it's good that there is someone specialising in that but as a rehabilitator, I think we still need to know how to do that."

Category 5: Management of low-level functioning mental health care users

Participants stated they had a need for more knowledge on the management of low-level functioning patients, especially those who are intellectually disabled. Nurses experience difficulty in the care and rehabilitation of these mental health care users. This category is illustrated by the following quotations:

> "I think all this intellectual disability, umm, these patients of intellectual disability, they are really a problem. I think, me, if I can get something, in-service about that because sometimes you can't even have groups in the ward."

> "... there was a certain speaker, she was talking about [the] type of patients she [is] nursing, the patients who are MR [mentally retarded] and profound [category of Intellectual disability] … it makes me to want to go for just little bit, maybe year or whatever, to go and work back with them; I developed interest."

Category 6: *Safety of staff members*

The participants described that at times they did not feel safe at the psychiatric rehabilitation centre due to certain behaviour of the care users; therefore they felt that they needed more knowledge on how to deal with the safety aspect of their daily work. They described how unpredictable the care users could be:

> "I want to know more about my safety as these people are not trustworthy."

> "… the person comes to you, you are from home, she slept here and then comes to you and fights, but yesterday you were like friends ... safety, much of safety."

Theme 3: Nursing skills required for the implementation of psychiatric rehabilitation

In Theme 3, nursing skills required for the implementation of psychiatric rehabilitation, two sub-themes emerged: interpersonal skills in nursing and rehabilitation skills. The sub-themes and categories in Theme 3 are presented in Table 3.4.

Table 3.4 Theme 3: Nursing skills required for the implementation of psychiatric rehabilitation

Theme	Sub-theme	Category
Theme 3: Nursing skills required for the implementation of psychiatric rehabilitation	Interpersonal skills in nursing	• Skill of listening • Skill of patience • Skill of observation • Skill of empathy • Problem-solving skills
	Rehabilitation skills	• Skills to communicate with mental health care users functioning at different levels • Identification of a relapse • Mental health care users' lack of understanding of an activity • Nurses lack of understanding of an activity • Implementation of sensory stimulation

3.3.11 Interpersonal skills in nursing

In the sub-theme "Interpersonal skills in nursing", participants described the nursing skills they needed in order to implement rehabilitation of the mental health care users. Five categories emerged from the data: s*kill of listening, skill of patience, skill of observation, skill of empathy* and *problem-solving skills.*

The literature states that the interpersonal skills needed include empathetic listening, interviewing skills and skills that facilitate a positive and trusting relationship between practitioner and client or patient. Research conducted on the effectiveness of training approaches that have an effect on the development of skills needed is limited. The academic curriculum does not generally prepare students to work as psychiatric rehabilitation practitioners or specialists (Corrigan et al 2008:74). The curricula for psychiatric nurse training and education programmes in South Africa aim at personal and professional development of the student. The student will become skilled in the diagnosing of health problems of individuals, families, groups and communities; the planning and implementation of therapeutic action and nursing care during any stage of life and evaluation thereof (R425, 1985, Paragraph 6 (2) (b)).

Participants described different interpersonal skills that are implemented in psychiatric nursing and in a psychiatric rehabilitation setting.

Category 1: Skill of listening

The participants described the importance of listening as a skill needed in psychiatry because in the opinion of the participants, listening by the nurses improves the well-being of the mental health care users. Taking the time to actively listen improves the relationship between the nurse and the care user and ultimately impacts on rehabilitation. The quotations of the participants below indicate as such:

> "I think, to listen to your patient is very important because they come with different ideas; to just, to listen to them what they are saying."

> "… the skill, aah that you need to have; firstly, listening, it's a good skill in psychiatry … because when they are at home there is like no one who is going to sit down and listen to them, at least, you know you make them feel good."

Category 2: Skill of patience

The skill of patience is very important in interactions with mental health care users. Participants described how they allowed the care users to take time in order to say or understand something, or to perform a specific task, especially the low-level functioning care users. Certain care users are unable to speak; therefore it is important for the nurses to be patient in order to understand them. The category is described by the following quotes:

> "With our patients in our ward we must be patient with them, give them time; some of them they are going to talk with sign languages and sometimes you don't know it; you might be patient until you understand what they are saying…. you must be patient."

> "… I mean patience, we need to be very patiently, also users, remember we can't rush them to be better. … Talking to them, be patiently, observing them …."

> "… about this kind of patient because we need to be patient with them … Bipolar patients they trigger any time."

Category 3: Skill of observation

Observation allows a nurse to notice behaviour that other members of the team may have missed. The nurses are with the care users twenty-four hours over the day and night and therefore observe what other members of the team will not see. After observation, the appropriate rehabilitation can be selected and implemented by the nurses. The following quotes describe the importance of the skill of observation:

> "… Because, observation it's very important, very important because you know, notice one small thing that others missed …."

> "I think it's an observation skill because you need to listen and observe …."

Category 4: Skill of empathy

Empathy was described as a skill needed in order to care for, treat and rehabilitate the mental health care users at the psychiatric rehabilitation centre. Putting the skill of empathy into practice allows for more effective care, treatment and rehabilitation of the care user. The participants described empathy as putting themselves in the situation of the other person; they also discussed how they implement the skill of empathy to treat the people in their care. The following verbatim quotations illustrate this category:

> "The other thing is like put yourself in their shoes and then know you, if it was, think, if it was your mother or father who's here then you'll want him or her to be treated how, so you treat them like equally according to how you treat your family."

> "I just wanted to say what she said, you must put yourself in their shoes, treat them with that love, give them the care, you must know their behaviour individually, you must understand them, give them their medication, their health education."

Category 5: Problem-solving skills

Participants explained how they go about identifying problems care users may have through questioning and identifying behaviour portrayed. Once these problems have

been identified, the problem-solving skills described by the participants come into play. The following quotes illustrate the skill of problem-solving:

The following two quotations link together:

> "Like maybe your patient, your patient undressed herself in public; you must just take her, you mustn't shout at her, you must just take her in a polite manner and put some clothing on."

> "Sometimes you must find out from the patient why is he undressing herself or himself, then you will find the reason; then deal with the problem of the patient."

> "At least I have learnt problem solving ... so I am able to intervene when they are fighting, listening and interviewing them. 'Why are you doing this?' You know, so at least problem-solving".

3.3.12 Rehabilitation skills

In the sub-theme "Rehabilitation skills", participants described the rehabilitation skills they need in order to ensure optimal rehabilitation of mental health care users. Five categories emerged from the data: *skills to communicate with mental health care users functioning at different levels; identification of a relapse; lack of understanding of an activity by a mental health care user; lack of understanding of an activity by nurses; and implementation of sensory stimulation.*

According to Neeraja (2008:46-47), the role of the psychiatric nurse has changed from that of providing custodial care to the dynamic approach of providing care during the rehabilitative process. A psychiatric nurse provides therapeutic, preventative and promotive psychotherapy and assists the multi-disciplinary team with therapeutic and rehabilitative activities.

Category 1: Skills to communicate with mental health care users functioning at different levels

Participants described the skills needed to communicate with mental health care users who function at different levels in order for rehabilitation outcomes to be met. The need

for the care users to understand what is expected of them in order to meet these outcomes was stated. The following verbatim quotes support this finding:

> "The high-functioning you, sometimes you just say it once and then they understand and do it exactly, and with the low functioning will repeat and repeat it and sometimes you say it slowly and then ask them to repeat what you said until make sure that they understand exactly what you are saying."

> "And mostly in those things on high functioning patients, just guide mostly, you just guide, just supervise mostly, in the low functioning level because in the low functioning level patient you have to do it more often so that they could understand really."

Category 2: Identification of a relapse

Implementation of appropriate care, treatment and rehabilitation strategies means nurses have to be able to identify when a relapse occurs. The importance of knowing and understanding the possible causes of a relapse were also discussed by the participants. The participants were aware of the possible causes of a care user relapsing while at home, as stated in the following verbatim quotes:

> "If the patient relapsed you're going to see that patient's not acting the same way as usual. … if you see that [is] not doing the same as used to then you must know that something is not right."

> "… so that you can see when they are out to relapse and before incidents can occur, so if you know your patient …you will be able to see, that no, this patient is not the same as before so if there is a need for you to call the doctor you can do that before we get incidents."

> "… starts to relapse, maybe he's walking around … the kids have got a bad impact because they like to follow those people, laugh and do funny things …."

Category 3: Lack of understanding of an activity by a mental health care user

Nurses have to facilitate understanding of activities by mental health care users. They need to ask certain questions of the user as well as of other nurses; they need to observe and assess understanding of the mental health care user concerning the activity. A lack of understanding on the part of the care user will prevent rehabilitation from taking place and the care user will not then be able to function at his/her optimal level. This category is illustrated by the following quotes:

> "Err, usually because we don't have OTAs [Occupational Therapy Assistants], ahh, if we, you find this one does not participate in the group activity; what we do is we move him to a simpler, err, activity and observe if, also, he can participate or doesn't like it also."

> "I've seen someone who I'll ask "Why are you not participating? And he'll say answer you correctly "It is boring for me." … that's when we intervene and say, we ask each other, what is the thing that, what is the activity that you think she will respond to."

Category 4: Lack of understanding of an activity by nurses

Participants discussed the importance of the nurses' understanding the activities in order to implement them. They stated that if a nurse does not understand an activity, she will not be able to assist the mental health care user with rehabilitation, as indicated in the statements below:

> "I'll ask the OT to help the group; to help the activity is done, that she can explain."

> "So how are you going to show them or tell them what to do when you don't know yourself? You need to know first, because you find at times there are patients who are very intelligent; who will ask a question like "Why are you doing this? Why do you need to do this? [Inaudible] Once starts seeing that you know you don't understand, he's not going to have confidence in you."

Category 5: *Implementation of sensory stimulation*

The participants described sensory stimulation that is implemented with the low-level functioning users which involves stimulating all the senses and assists with memory. It emerged from the discussion that rehabilitation skills are needed in order to implement it and to allow for improvement to take place.

> "Sensory stimulation [pause]; it's when, okay, you, there's a long procedure, you start going individually to patients maybe you've got something to give them to smell or some cloths like cloth, ... so that they should feel something."

> "I like sensory stimulation because it, it [is] like the way we are stimulating, the way it stimulates their minds … there are those who have smelt something, maybe there is a different smell that they were smelling ... and she remembers, so sensory stimulation, it, it makes them remember things that they know …you can see it on their smile and it is a very good feeling even to the one doing the sensory stimulation."

> "… see the changes that they are doing because and they change immediately even the way they were sitting first before the sensory stimulation."

Theme 4: Means of communication within psychiatric rehabilitation

In Theme 4, means of communication within psychiatric rehabilitation, three sub-themes emerged: verbal communication, non-verbal communication and written communication. The sub-themes and categories in Theme 4 are presented in Table 3.5.

Table 3.5 Theme 4: Means of communication within psychiatric rehabilitation

Theme	Sub-theme	Category
Theme 4: Means of communication within psychiatric rehabilitation	Verbal communication	• Talking • Asking questions • Allowing expression of feelings • Interviewing mental health care users
	Non-verbal communication	• Therapeutic touch • Listening to the mental health care users • Sign language
	Written communication	• Communication by low level functioning mental health care users • Importance of record keeping • Monthly reports

3.3.13 Verbal communication

In the sub-theme "Verbal communication", participants described the verbal communication they use in order to ensure understanding of the mental health care users, which in turn facilitates rehabilitation of the mental health care users. Four categories emerged from the data: *talking to the mental health care users, asking questions, allowing expression of feelings* and *interviewing the mental health care users.*

Morrissey and Callaghan (2011:1) discuss the importance of communication in psychiatric rehabilitation, as it is an important part of therapeutic interventions. Interpersonal skills are essential in helping the person who is experiencing mental health problems. Many appropriate and effective communication and engagement skills need to be implemented by a psychiatric rehabilitation practitioner.

Category 1: Talking to the mental health care users

Information is obtained from the care users in different ways and the participants described how they talked to the users in order to obtain the information needed. They emphasised talking individually to the care users in order to implement the appropriate rehabilitation for that specific individual.

> "I think also one-to-one talk can help, err, in this way of "Tell me more" because if the patient can only tell you one thing then you keep on saying "Tell me more"

> "Ja, I think it differs because some of them when you try to get information … that you need to sit down and talk …."

Category 2: Asking questions

The participants ask the mental health care users different questions in order to obtain further information, assess the level of functioning and identify behaviour. The information obtained and assessment performed then allows for planning and implementation of rehabilitation to follow. This category is illustrated by the following quote:

> "[laughs] Ja, mostly the questions that we normally ask is to find out, umm, the history, more history of the patient and what he knows or what he did previously …."

Category 3: Allowing expression of feelings

Participants believed that they should allow care users to express their feelings verbally in order for the nurses to understand the users' problems and feelings. This would assist them to implement the appropriate care, treatment and rehabilitation. The following verbatim quotation supports this finding:

> "To add to that it is important to be open to your patients, to be friendly, when to allow them to express their feelings … then you can go to ask and to call her, in private and ask "Tell me, what is wrong? What is your problem?"

Category 4: Interviewing mental health care users

Participants explained that interviewing of mental health care users is another method used by them to gain information as well as to communicate verbally with them, especially when problem behaviour occurs. Interviewing is performed individually with the care user without any interruptions from other care users and allows users to express how they are feeling, as indicated by the quotes below:

> "Okay, by interviewing them, umm, is then that you can find that others they can express themselves verbally and others they [can] non-verbally."

> "But even when you see the problem to the patient you have to interview the patient, the patient you see that there is a change in the behaviour. I mean you have to have a one on one session so that you can find out the problem …."

3.3.14 Non-verbal communication

In the sub-theme "Non-verbal communication", participants described the non-verbal communication they used in order to communicate with the mental health care users. Four categories emerged from the data: *therapeutic touch, listening to the mental health care users, sign language,* and *communication by the low level functioning mental health care users.*

Category 1: Therapeutic touch

Participants explained that they use therapeutic touch as part of their non-verbal communication with the mental health care users. Therapeutic touch is the appropriate use of touch in psychiatric nursing; if used inappropriately it could affect the rehabilitation of a care user. They described what they understood it to be. This category is illustrated by the following quote:

> "Maybe when I get to the patient by holding her with her hands not any part of the body … that is therapeutic touch."

Category 2: Listening to the mental health care users

Participants discussed the importance of listening to the mental health care users and explained that this is non-verbal communication used by nurses. Active listening is used to show care and concern. The category is illustrated by the following quotes:

> "By giving them love by being there for them by showing caring and listening to them."

> "… to know how to direct and understand with a good listening whatever the patient is saying to you."

Category 3: Sign language

Participants expressed the need to be able to communicate in sign language with mental health care users who are deaf or hard of hearing. Communicating with these care users is difficult for the nurses if they do not use sign language. The use of sign language allowed the participants to understand what rehabilitation would be needed for these care users. The statement made by a participant is an indication of the discussion.

"Coming back to communication … we are lacking somewhere because we have patients who are deaf and dumb and we don't have any of the staff who is taken to learn sign language, so it is really difficult for us to get through to those patients."

Category 4: Communication by low-level functioning mental health care users

According to the participants, many of the low-level functioning users are unable to speak and therefore communicate using gestures and other non-verbal cues. Understanding the gestures and cues of these care users is important in order to implement the appropriate care, treatment and rehabilitation for them, as indicated by the verbatim quotes:

> "… some other patients don't even know how to talk or not able to talk by themselves, they [are] not used to saying anything but you can see by their actions, can see what he is portraying there, shows there is something wrong or there is a need, …."

> "Through their gestures, maybe the one comes and do like this and you know that she wants you to go to family, others do pointing, [mumble], then I go and check know something is wrong, through gestures most of the time."

3.3.15 Written communication

In the sub-theme "Written communication", participants described the importance of written communication in the treatment, care and rehabilitation of mental health care users. Two categories emerged from the data: *importance of record keeping* and m*onthly reports.*

The nurse is the health care professional mainly responsible for keeping records of mental health care users and these records include information on health care and the response of the user to the medical and nursing care (Geyer 2007:7).

Category 1: Importance of record keeping

The participants discussed the importance of record keeping as a means of communication with one another. Mental health care users are not always able to give information and therefore the only way nurses will know what is happening with the user or any change in behaviour is through the records. This applies to all nursing situations, not only within a psychiatric setting. This is illustrated by the quotes below:

> "I think that is where record keeping sets in here because some of the patients cannot give any information, so when you go back to the file that's where you can get information…. that is why I say record keeping fits in here."

> "And then you don't have to forget to record that, you know so and so behaved this way because so and so doesn't drink his medication."

Category 2: Monthly reports

The participants explained that they had to write monthly reports on each mental health care user in their wards and what information was recorded. A participant also stated that this formed part of the evaluation of the mental health care user, as seen in a statement quoted below:

> "… writing of ahh, their Cardexes on monthly basis, to some patients, it becomes boring, the reason being that it depends on their level of functioning, you know

> there are patients who have been here say for ten years, when you refer to the notes, maybe two years ago you read and read the assessment, when you look at that patient, there is no improvement that patient is still the same ...."

> "… before you write your monthly report you check what happened for the month …."

3.4 EMERGING RELEVANT OUTLIERS

Some of the comments made by participants were only stated once and did not fit in with any of the themes but were deemed important. The comments related to the nurses' role as psychiatric nurses and their feelings concerning psychiatric nursing, which in turn affects the implementation of mental health care users' care, treatment and rehabilitation at the psychiatric rehabilitation centre.

Quotation 1: Special role of the psychiatric nurse

The participant described a previous experience which involved the emotional connection a psychiatric nurse had with her patients. The connection is perceived as a special skill by those the nurse comes into contact with, which impacts positively on care, treatment and rehabilitation of each individual.

> "Yes, I can add on that, you know, when I was training our tutors liked us more than anybody else, and the patients loved us so much, they will tell you, "You are dealing with our souls, when you touch us, there is a difference"; then we have a special skill, we have it."

Quotation 2: Professional pride of a psychiatric nurse

The statement made by the participant indicates the professional pride felt by this particular participant concerning psychiatric nursing and how this will impact positively on the care users and the implementation of their rehabilitation.

> "… It makes me proud to be a psych nurse, just to know that other people are also proud of their jobs, it makes me happy."

Quotation 3: Psychiatric nursing as a profession

The participant believes that she made the correct choice of profession in choosing psychiatric nursing and is very positive about continuing with rehabilitation of the mental health care users at the psychiatric rehabilitation centre.

> "I feel very good after this because now I have confidence and I know that I have chosen the correct career for myself and with the support system of my colleagues here, you know I feel like doing more of [laughs] rehabilitation."

3.5 CONCLUSION

This chapter presented the themes concerning the rehabilitation process: knowledge of the nurses regarding rehabilitation; the need for CPD; skills of nurses required for the implementation of psychiatric rehabilitation and means of communication within psychiatric rehabilitation, the sub-themes and categories that emerged from the data analysis. The themes, sub-themes and categories were supported by quotations from the participants in order to achieve the objective of the study, which was to explore and describe the knowledge and skills nurses in a psychiatric rehabilitation setting have regarding rehabilitation of mental health care users, in order to develop a continued professional development plan for nurses working in the centre.

Chapter 4 presents the literature that supports the themes, sub-themes and categories that emerged from the data.

CHAPTER 4

FINDINGS AND COMPARISON WITH THE LITERATURE

4.1 INTRODUCTION

The data analysis of the discussions in the focus groups in this study was presented in Chapter 3.The themes, sub-themes and categories that emerged from the data were presented in tables and substantiated by verbatim quotations. This chapter presents a discussion of these findings and the literature that supports the findings.

Qualitative research does not start with an extensive literature review because its purpose is to place the findings in the context of what is already known. According to some qualitative researchers, no literature review should commence until the analysis is complete, in order to prevent the possibility of the research developing bias or assumptions regarding the topic concerned and leading the participants in the direction of what the researcher believes (Streubert Speziale & Carpenter 2011:25-26).

The central aspect of the study should be understood through the presentation of the findings; therefore they need to correlate with the data analysis and the literature reviewed (LoBiondo-Wood & Haber 2010:179).

4.2 DATA ANALYSIS

Data were analysed using the steps described in Streubert Speziale and Carpenter (2011:45-46). The description of these explained how the categories, sub-themes and themes emerged.

The themes that emerged from data collected during four focus groups were:

- Knowledge of the rehabilitation process
- The need for continuing professional development
- Nursing skills required for the implementation of psychiatric rehabilitation

- Means of communication within psychiatric rehabilitation

Sub-themes and categories also emerged from the data.

4.3 DISCUSSION OF THE FINDINGS AND COMPARISON WITH THE LITERATURE

4.3.1 Knowledge of the rehabilitation process

In Theme 1: Knowledge of the rehabilitation process, nine sub-themes emerged from the data.

Participants elaborated on their current knowledge and the application thereof in the rehabilitation of mentally ill patients. The nine sub-themes: the meaning of rehabilitation, assessment of mental health care users' functioning, planning of rehabilitation, implementation of activities, implementation of education, evaluation of care users' response to rehabilitation, the value of the multi-disciplinary team, management of mental disorders and signs and symptoms thereof, and the therapeutic relationship with mental health care users within the rehabilitation process were important aspects that were discussed in the focus groups.

4.3.1.1 The meaning of rehabilitation

The meaning of rehabilitation, according to participants, is that the mental health care user can *return to the community and function independently,* rehabilitation *changes lives,* and it is important *how mental health care users are handled.*

According to the Mental Health Care Act (Act 17 no of 2002), rehabilitation is the process that assists an individual to achieve an optimal level of independent functioning (South Africa 2002:5). Psychiatric rehabilitation is defined as a therapeutic approach that allows mentally ill people to develop to their fullest capabilities through learning and support (Corrigan et al 2008:50). Psychiatric rehabilitation can be understood as organised efforts to assist people with mental illness to move forward in their recovery (Corrigan et al 2008:52). The participants understand rehabilitation to be able to assist

care users to return to the community and function at their own independence level which, as discussed in the literature, allows development and progress.

Rehabilitation includes self-care, self-sufficiency, encouragement of maximum independence, maintenance and restoration of optimal functioning and promotion of maximum potential. It emphasises abilities, promotes adaptation, restores an acceptable quality of life, maintains dignity and promotes wellness (Mauk 2012:2). The above literature sources support the participants' understanding of rehabilitation and its contribution to changing the lives of mental health patients in a holistic way.

The nurse needs to handle the care user as a holistic person who presents with his/her own background and environment, having strengths, behaving in a certain way and having own problems and not to be labelled as a nobody because of being mentally ill or someone who can be manipulated (Schultz & Videbeck 2009:9). In line with this, the participants explained that rehabilitation is about the way the care users are treated and handled in a specific way, which is by respecting them and treating them equally.

4.3.1.2 Assessment of the mental health care users' functioning

Participants explained that rehabilitation commences with an assessment of the mental health care user within the rehabilitation process. According to Uys (2010c:188), the first step in the process is assessment of the patient or group. Planning based on information obtained on assessment follows, and then implementation of the planned care. Evaluation takes place once interventions have been implemented.

It was ascertained that the participants understood that assessment is done in order to *determine the level of functioning* of the mental health care users; that it allows for the implementation of *rehabilitation activities* and that *certain information is obtained on assessment* of the care user.

The theory of creative ability provides a framework for assessing the mental health care users' occupational performance according to skills accomplished in the personal, social, work and recreational occupational performance areas. The assessment determines the level of functioning of the user (De Witt 2005:3-4). Assessment is done by the multi-disciplinary team when a patient is admitted. The outcomes of the

assessment assist with grouping of patients according to their level of functioning, and strengths and weaknesses of individuals are taken note of (Venter & Zietsman 2005:199). Mental health care users who function at different levels are admitted to the rehabilitation centre; therefore the importance of assessment to determine the level of functioning of the care user was emphasised.

The findings of the participants are supported by these literature sources. Carniaux-Moran (2008:40-41) explains that one of the psychiatric nurse's most essential skills is being able to assess a patient. A comprehensive nursing assessment is a requirement for the formulation of appropriate nursing diagnoses and the planning of suitable care. The information obtained on assessment provides a baseline level of functioning that is used to evaluate, adjust and respond to the plan. The literature thus supports the finding that assessment allows for the implementation of appropriate care, including group activities, which form part of rehabilitation.

Participants explained that information on the care users' history, orientation to all spheres (i.e. time, place and person and insight into their mental illness) was information that is obtained through assessment: this is supported by the literature, which also describes the important information that is obtained. According to the literature, a comprehensive assessment involves a patient's experiences of life and psychiatric illness and includes the patient's history: the course of the illness, social and personal history and stressors, and the mental and physical condition of the patient (Pietersen & Middleton 2010:199).

4.3.1.3 Planning of rehabilitation

Planning of patients' care follows assessment in the rehabilitation process (Uys 2010c:188).

Participants revealed that they planned rehabilitation *according to problems identified* in order for the plan to be specific for that individual and his or her needs and that the important *planning of individual rehabilitation* of the care users took place. In order to implement rehabilitation according to each individual's needs, planning for each individual must take place. According to Neeraja (2008:45), the nurse evaluates the

nursing care implemented by assessing the response and progress of the care user, revises the nursing diagnosis and plans the nursing interventions accordingly.

A rehabilitation plan guides the nurse and mental health care user through the recovery process. The plan needs to be revised on a regular basis and involves specific goals, interventions and targets that need to be met. It must be clear and concrete in order to see if the plan works or not (King, Lloyd & Meehan 2013:81).

The nurse has the challenge of discovering the needs of each individual, especially those needs that have not been met, in order to develop a rehabilitation approach that meets the needs of these individuals (King et al 2013:71). The psychiatric nurse develops an individualised plan of care which identifies the interventions that need to take place in order for the expected outcomes to be met. The plan provides continuity of care and rehabilitation and reflects current nursing care (Ballard 2008:27). This literature supports the views of the participants about the importance of planning appropriate rehabilitation in relation to their individual needs. The literature does describe specific aspects involved in planning which the participants did not mention, such as specific goals, interventions and targets. The participants did, however, emphasise the importance of planning.

4.3.1.4 Implementation of activities

Nursing actions are identified and implemented to assist the patient in meeting the planned goals. The nursing actions implemented may include counselling, milieu therapy, self-care activities, administration of medication, health education and health promotion (Ballard 2008:27).

The implementation of *specific group activities* at the psychiatric rehabilitation centre was discussed. Participants confirmed the fact that some of them did not involve themselves in these group activities.

Activity therapy is the belief that people can benefit from participating in activities that focus outside themselves, such as exercise, crafts, writing, music or painting. These activities can be done either individually or as a group (Taylor 2008:8). A study done in Shanghai, China, found that people with schizophrenia who participated in a

rehabilitation programme demonstrated markedly better improvement than did the control participants. The rehabilitation programme is effective in meeting psychosocial deficits in people with schizophrenia and should be implemented widely, as advised by Pan et al (2011:301, 304). The study discussed in the literature reveals the importance of implementation of a rehabilitation programme that includes specific activities. The participants in the current study described the specific activities they implemented, such as discussion groups on specific issues or behaviour of the care users and health education groups, for example on smoking.

The participants discussed the fact that the activities involve learning and seeing what progress has taken place, as is indicated by the literature. According to Uys (2010b:248), activity groups are made up of a specific structured activity, around which interaction between the members takes place. This needs to be therapeutic by ensuring that progress occurs, problems are shared, group cohesion occurs and learning and socialisation take place.

Activities are implemented according to the level of functioning of the mental health care users. Participants distinguished between activities for low-level functioning users and those who function at a higher level. Activities for low-level functioning users included sensory stimulation and building puzzles. Activities that were considered as suitable for high-level functioning users include attending climate meetings and health education.

The literature supports the use of sensory stimulation as an activity for low-level functioning mental health care users. Sensory stimulation is a multi-modal activity used for the low-level functioning mental health care users and involves linking the senses to make sense of the world. The skin, hands and feet are touched; hearing involves listening to certain sounds, localising sounds and the sensations thereof. The proprioceptive sense is stimulated through body positioning, whereas the vestibular sense involves movement, gravity and changing head positions. Smell, together with taste, induces emotion and memory (Longhorn 2006).

Community meetings, also known as climate meetings, are an integral part of a psychiatric ward routine and have not always had a clear purpose and value. According to Novakovic, Francis, Clark and Craig (2010:45-46), the main intention of bringing patients of the ward together is to address day-to-day issues relating to their life. In

practice, many climate meetings do not occur regularly and are often dominated by complaints relating to problems regarding inadequacies of ward provision. Patients often complain that these meetings are not worthwhile because issues raised are not dealt with. However, the description in the literature source of a climate meeting indicates it is an activity for higher functioning care users, as stated by the participants.

Activities of daily living, which include mental health care users' making their beds and performing oral hygiene, take place on a daily basis at the psychiatric rehabilitation centre or at home, and the participants' descriptions are supported by the literature on activities of daily living.

Fouche (2005:399) states that activities of daily living consist of personal activities and instrumental activities. Personal activities include bathing, showering, dressing, eating, feeding, mobility, personal-device care (for example contraceptives), personal and toilet hygiene, grooming, which includes putting on make-up, sexual activity, sleep and rest. Instrumental activities include interacting with the environment such as caring for others, care of pets, raising children, financial management, health management, preparation of meals and cleaning up afterwards, safety procedures, emergency response and shopping.

Data emerged from the participants in this study that *activities* are initiated by the nurses for the care users in order to prepare them *for discharge.* These activities occur once rehabilitation has taken place and the care user has reached his or her optimal level of functioning at the centre.

Planning for discharge should commence when the care user is admitted to the rehabilitation centre and needs to be included in the first care plan devised for that individual. As hospitalisation is a temporary measure, planning for discharge should be part of the rehabilitation throughout the hospital stay (Schultz & Videbeck 2009:45). The nurse assists the care user to assess own personal needs and to make a time schedule so as to structure activities such as work, recreation and social activities. Users need to be taught about their mental illness, medication, nutrition and exercise. The nurse discusses ways to meet personal needs such as grocery shopping, clothing, managing money and contacting community resources (Schultz & Videbeck 2009:47). The statements of the participants and the information given by them is supported by what is

referred to in this literature source, in that the participants understand that teaching specific skills is an activity important for preparation for discharge, even though the participants did not discuss when the planning for discharge commences.

4.3.1.5 Implementation of education

Patient education has been described as an integral part of the rehabilitation process. Participants explained that *education of the mental health care user* and *education of their families* form part of implementation of rehabilitation.

Mental health education offers individuals, their family members and groups knowledge and understanding of the promotion of mental health and prevention of mental illness. The aim of education is to improve understanding, knowledge and skills of the person in order to help him or her manage daily problems in a more effective way. Education increases understanding, knowledge and capability of the family, thereby allowing them to manage mental illness effectively and responsibly (Uys 2010b:251-252).

Psycho-education is one of the most empowering interventions implemented by the nurse and involves teaching the mental health care users and their families about the condition, treatment being given and the management thereof. Psycho-education increases the care users' and families' ability to cope with mental illness and to decrease the chance of a relapse (Uys 2010b:258). Nurses know the needs of the mental health care user through their illness and treatment plan, and teaching allows the nurse to clarify health information to the care user and family members (Neeraja 2008:69).

This literature supports what the participants specified in the study about the importance of education of the mental health care users as well as their families. Patient education, regarded as important by the participants, relates to the importance of compliance with treatment, of not taking drugs and alcohol and of educating families to treat mental health care users in a humane manner.

4.3.1.6 Evaluation of care users' response to rehabilitation

Evaluation is an on-going activity included in the whole process in order to evaluate and revise the other steps of the process (Schultz & Videbeck 2009:23).

Reasons for evaluation, according to the participants, are to gauge if there is any improvement or progress on the part of the care user in relation to rehabilitation. *What evaluation entails* also emerged from the discussions; asking questions forms part of evaluation, together with progress on problems and response to activities. Evaluation enabled participants to take note of the progress or any changes that had taken place. According to Schultz and Videbeck (2009:23), evaluation needs to be included in the mental health care users' daily care. Each observation and interaction between them and the nurse provides an opportunity to evaluate a section of the mental health care users' care plan.

A psychiatric nursing evaluation covers the assessment, nursing diagnosis, expected outcomes and planning stages. The evaluation is an on-going process. As more information on the individual's history emerges and new insights into problems experienced are gained, the diagnosis and treatment plan for that individual changes accordingly (Carniaux-Moran 2008:40). This is in line with the participants' understanding that evaluation identifies both the progress and the problems experienced by the care users.

4.3.1.7 Role of the multi-disciplinary team

The *role of the multi-disciplinary team in rehabilitation* was described in this study. The specific roles that different multi-disciplinary team members have within the psychiatric centre and within rehabilitation were explored. The literature confirms the importance of a multi-disciplinary team approach in psychiatric rehabilitation, as well as the role of the team and specific members of the team.

Barry (2002:25) states that the ability to make a prompt and comprehensive assessment of a patient and provide treatment in an in-patient setting requires a cohesive team of health professionals who have comprehensive skills in assessing and treating mental disorders in an environment that is safe and therapeutic. The team

works together in order to develop a plan that identifies ineffective coping and social behaviour and sets objectives or goals for more effective behaviour. To implement the plan in order to achieve the goals, each team member needs to know and understand his or her role in the discharge planning of the patient (Barry 2002:29).

Participants explained that they would refer the mental health care user to the multi-disciplinary team when problems were observed, such as a care user's not responding when activities took place. They would discuss certain care users with specific team members, such as the doctor or social worker, when specific problems arose.

4.3.1.8 Management of mental disorders

Knowledge that the participants possessed included *management of the signs and symptoms of mental illness;* they explained that they were able to recognise signs and symptoms exhibited by the care users, and knew how to manage the user according to the signs and symptoms; they also described their knowledge on the *management of specific mental disorders* such as intellectual disability and schizophrenia. Uys (2010a:17) maintains that mental health nursing is an interpersonal process, and knowledge of human behaviour in sickness and health is important. Various treatment modalities, such as individual therapy, family therapy, group therapy, milieu therapy and crisis intervention are considered, implemented and evaluated (Taylor 2008:14-17). The literature thus supports the importance of nurses' having knowledge of the signs and symptoms of different mental illnesses and the management thereof.

4.3.1.9 Therapeutic relationship with mental health care users within the rehabilitation process

The participants described their knowledge about and views on the *nurse-patient relationship, the importance of knowing the mental health care user, acknowledgement that mental health care users should be treated with respect and dignity* and *understanding cultural and religious beliefs.*

According to Neeraja (2008:197), a therapeutic nurse-patient relationship requires genuineness, sincerity, respect, empathy and concern from the nurse. It also requires

that the nurse show love and affection, be an active listener, be a role model, have good communication skills and be able to explore problems.

The therapeutic relationship between the nurse and mental health care user is built on trust; there are specific goals and expectations. The trust relationship is focused on the mental health care user in terms of learning, meeting needs and allowing growth. The responsibility of the nurse is to facilitate and guide the relationship in order for the goals to be met (Schultz & Videbeck 2009:40). The participants described the nurse-patient relationship as a relationship of trust with the focus on the care user. The participants believed that such a relationship allows for rehabilitation to take place, which is their goal. The literature referred to confirms the goals of meeting needs and allowing growth.

The participants described their understanding concerning the *importance of knowing the mental health care user* and the needs of the care users in order to plan and implement rehabilitation for each individual, as is supported by the literature (Lambert 2012:17 & 19). In order for nurses to know their patients, they need to carry out a risk assessment to observe any physical health problems. The nurse needs to understand the effect of demographics such as age, ethnicity and the mental health diagnosis of the patient, including signs and symptoms displayed, any substance use and medication.

In-depth knowing of the patient enables the nurses to meet any unmet needs (Lambert 2012:17). Working with care users, nurses develop a better understanding of what is important to the users in terms of their well-being; this leads to improved self-esteem (Lambert 2012:19), which allows the users to be open to rehabilitation.

There was consensus among participants that mental health care users *should be treated with respect and dignity.* Treating the care users as human beings and showing respect and treating them with dignity builds their self-esteem and this in turn assists with rehabilitation.

According to Mauk (2012:1), the idea of rehabilitation originated from the assurance that all individuals have worth; each person is seen as unique, a comprehensive and holistic being. A principle of psychiatric nursing is that the mental health care users need to be accepted exactly as they are. Acceptance shows love and care; it lowers anxiety levels and the feeling of being threatened, and the acceptance assists the

mental health care user to portray positive behaviour (O'Carroll & Park 2007:39-40). A therapeutic relationship encompasses concerns of the patient as well as specific ideas of how the patient needs to be treated, which is with equality, empathy, dignity and respect (O'Carroll & Park 2007:29).

The literature supports the importance of acknowledging the worth of a person as well as treating the person with respect and dignity, as was discussed by the participants. The positive feelings that result, such as improved self-esteem and decreased anxiety on the part of the care users, will in turn help them to participate in the rehabilitation process.

The participants described the importance of *understanding cultural and religious beliefs* of the care users, and explained how this information was acquired by the nurses, by asking the care user or the family members about their beliefs. This understanding is important in order to implement the appropriate rehabilitation programme for that individual.

According to McQuaid, Marx, Rosen, Bufka, Tenhula, Cook and Keane (2012:128), it is very important to meet the diverse cultural needs of people who are served within the mental health sector. Health care professionals need to take note of, incorporate and apply culturally competent approaches to assessment and treatment to optimise the care provided to care users from different racial and ethnic backgrounds. Race, ethnicity and religion affect the response of patients to medication prescribed and behavioural interventions. Therefore, understanding the patient's background is needed in order to implement treatment.

Culture can influence the development, appearance and reporting of mental illness and can affect the diagnosis given. A nurse who is not familiar with the different aspects of a person's culture may perceive behaviour to be part of a psychiatric illness, when actually the behaviour may be part of the culture of that individual.

Religious belief is associated with higher levels of social support, decreased depression rates and higher levels of cooperation and cognitive functioning. Nurses need to be in touch with their own spirituality in order to carry out an in-depth and competent spiritual assessment of the patient. The nurse should use active listening skills, be non-

judgemental and not impose his or her own personal beliefs on to the patient (Carniaux-Moran 2008:44-46). The literature thus supports the participants' perceptions of the importance of understanding cultural and religious beliefs in order to implement appropriate care, rehabilitation and treatment.

4.3.2 The need for continuing professional development

The participants expressed their needs regarding additional knowledge which they perceived to be important for their role at the centre. The need of the participants to know more about specific management and handling of people suffering from mental illness within a psychiatric setting would be met through a continuing professional development plan.

Psychiatric rehabilitation practitioners must have theoretical and practical knowledge. Theoretical knowledge is needed on psychology, psychopharmacology, counselling approaches, assessment, psychiatric rehabilitation models and deinstitutionalisation. Practical knowledge on the functioning of service systems and local community resources is needed to be a competent psychiatric rehabilitation practitioner (Corrigan et al 2008:73). Theoretical knowledge is knowledge of the principles and ideas of the subject: knowledge gathered from the books on the subject. Practical knowledge is the way the principles are put into practice and knowing how something can be used or applied (UnivSource 2009). Knowledge is the foundation of effective practice: knowledge of policy, legislation, mental health and the services offered. Knowledge of these and other different areas is needed in order to provide an effective service (O'Carroll & Park 2007:9). Therefore the literature endorses the participants' assessment of the importance of knowledge in a psychiatric rehabilitation setting.

4.3.2.1 The need for further knowledge

Participants expressed the need to further their knowledge on various aspects of psychiatry and rehabilitation.

Participants expressed a need to obtain more knowledge on *characteristic behaviour portrayed by people who suffer from specific mental conditions, management of mental illnesses, substance abuse by mental health care users, specific rehabilitation activities,*

management of low-level functioning mental health care users and *safety of staff members.*

Continuing competence is defined as “the constant ability of a nurse to integrate and apply the knowledge, skills, judgments and personal qualities needed to practise safely and ethically in a specific role and setting”, as described by the Canadian Nurses’ Association and Canadian Association of Schools of Nursing in the ICN Position Statement (International Council of Nurses 2006:2). The primary aim of continuing professional practice in nursing is to improve quality of patient care. Nurses need to know that updating knowledge is important to providing that quality of patient care (Davids 2006:1).

Mental health practice needs nurses who offer more skilled and effective psychiatric nursing. Gaining new therapeutic skills and learning how to use these skills effectively should also improve knowledge in order to provide best practice in different situations (Morrissey & Callaghan 2011:61). The United Kingdom promotes the provision and facilitating of education in practice in order to close the perceived gap between theory and practice in nursing (Graham & Bond 2008:52).

According to the World Health Organization (WHO 2011:112), in the absence of rehabilitation specialists, health care professionals with appropriate training can assist in meeting service shortages as well as supplementing services by, for instance, following up on therapy services. The training programmes for these health-care professionals should be user-driven, according to needs, and relevant to the roles of the professionals. The training has many benefits, including the reduction of staff burnout, improved implementation of rehabilitation, increased patient participation in rehabilitation and increased satisfaction among the team.

The participants discussed the need for further knowledge on specific *mental illnesses, the behaviour thereof and the management of mental illness.* This is supported by the literature, which holds that more training is needed on mental disorders in the community and on mental health within primary health care. The need for more knowledge on skills required for the implementation of rehabilitation emerged from the data; the literature concurs that the learning of new knowledge and skills ensures best practice within a psychiatric setting.

The participants expressed the need to improve their knowledge on the skills taught in the occupational therapy department concerning *specific rehabilitation activities* so that they could assist the users in their rehabilitation. The participants discussed specific activities such as cooking, candle making and mending of shoes; by knowing how to assist the care user in these activities the nurse would be able to guide the care user in long-term planning, as is endorsed by the literature. According to the American Occupational Therapy Association (2011), the knowledge and skills of occupational therapy include helping the care user to engage in long-term planning such as budgeting, planning for meals and activities to improve mental health.

Participants described a need for further knowledge on *the management of low-level functioning care users,* as they found it difficult to care for and rehabilitate these care users. This knowledge is needed to ensure the appropriate care and rehabilitation is given, especially for those with severe intellectual disability. The literature illustrates the teaching outcomes needed to ensure knowledge is gained. The learning outcomes for a programme on the care of people with intellectual disability include being competent in the method of interaction with the patient, understanding the patients as individuals, gaining specific problem-solving skills and understanding the importance of a comprehensive approach (Lindsay 2013:6-8).

The participants expressed a need to gain knowledge about *safety of staff members* at the psychiatric rehabilitation centre. Feeling unsafe at the centre while on duty could jeopardise the planning and implementation of rehabilitation at the level expected of them. According to Wolfson, Holloway and Killaspy (2009:22), rehabilitation centres should provide a safe environment that ensures stability and security. Wolfson et al (2009:29) also state that services need to implement risk management, including management of risks to the individual care user and others, which involves the staff and other care users. According to Trinkoff, Geiger-Brown, Caruso, Lipscomb, Johantgen, Nelson, Sattler and Selby (2008:14), environmental and organisational factors such as poor staffing, inadequate security and transporting patients have contributed to incidents where health care workers have been assaulted by patients or family members. Having visible security staff reduces the rate of assaults, but this increases the perception that assaults are part of the job; therefore they need assault prevention training and a higher staff/patient ratio.

4.3.3 Nursing skills required for the implementation of psychiatric rehabilitation

Participants stated that specific skills should apply to nurses who practise in a mental health care environment. These are discussed in relation to the literature on the topic.

Mental health practice needs nurses who offer more skilled and effective psychiatric nursing. Gaining new therapeutic skills and learning how to use these skills effectively should also improve knowledge in order to provide best practice in different situations (Morrissey & Callaghan 2011:61).

4.3.3.1 Interpersonal skills in nursing

Interpersonal skills needed in order to implement rehabilitation within the psychiatric setting include the *skill of listening, skill of patience, skill of observing, showing empathy* and *problem-solving skills.*

Skills needed by a competent psychiatric rehabilitation practitioner are extensive. The skills needed include empathetic listening, interviewing skills and skills that facilitate a positive and trusting relationship between practitioner and client or patient (Corrigan et al 2008:74). Therapeutic listening skills are needed in order for the nurse to actively listen to what the mental health care user is saying, verbally and non-verbally (Uys 2010c:177). The participants discussed the importance of the skill of listening in order to improve the well-being of the care user, which in turn impacts on rehabilitation; the literature source above supports this.

Heacock (2013) stresses that a nurse needs to have an abundance of patience in order to carry out daily tasks. The nurse may need to handle a quarrelsome patient, deal with angry family members, and handle a moody colleague or difficult supervisor, as well as dealing with the daily routine work of the ward or department. Heacock describes how important patience is on a daily basis within nursing. The participants likewise described the patience they needed on a daily basis to deal with different care users in order to implement the appropriate rehabilitation.

Observation is active, objective and free of judgement. While observing a patient and problems associated with the patient’s illness, nurses also observe any progress that

has taken place. Observation is an essential skill that every nurse needs to be competent in and involves the use of logical, emotional and organisational abilities. Observing enables the nurse to get a better understanding of a patient and his or her reactions, behaviour portrayed and signs and symptoms that have manifested themselves (Phaneuf 2007:1-2). Many difficulties arise in recognising mental illness, especially in people with intellectual disability. It is therefore important for nurses to have communication skills, understanding and observation skills to identify signs and symptoms within mental illness (Harmon, Petrie & Taua 2012:223). In line with this, the participants in the current study emphasised the need for observation skills in order to implement rehabilitation that was appropriate for that individual. Observation allows the nurses to understand their care users and their behaviour.

The skill of empathy is more than a way of being with a person or an attitude. It is more like saying "I am with you and I have listened carefully to what you have said and expressed and I am hoping I understand correctly". Empathy is warmth and genuineness, which are just as important as the words used (Reynolds 2005:103). Empathy is the sharing of feelings, thoughts and ideas of another person, connecting with the individual and understanding him or her, as well as the feelings expressed by that person. The nurse communicates to the user that the feelings expressed are understood. The nurse embraces the viewpoint of the mental health care user and is therefore more likely to see situations or problems as the user does (AntaiOtong 2007:31). Thus the literature supports the importance of the skill of having empathy, which was discussed by the participants. They also described empathy as putting themselves in someone else's situation. Applying this skill allows the nurse to care for, treat and rehabilitate the care user more effectively.

Skills needed at the psychiatric rehabilitation centre also include *problem-solving skills,* according to the participants' discussions in the focus groups. These skills are executed once problems have been identified through questioning and identification of behaviour portrayed by the care user.

Problem-solving skills, together with sharing of ideas, decision making and personal growth, are part of interpersonal skills. These skills allow for the development of strategies that bring positive changes to the mental health care users' mental status (Neeraja 2008: 68-69). Problem solving comprises identifying a problem and making

choices that direct the care toward desired outcomes. Effective problem-solving skills are important in the delivery of competent nursing care, and nurses need to practise these skills in a systematic way in order for them to be effective (Lipe & Beasley 2004:19, 25). In line with the literature, the participants explained that they identified various problems the care users had and then used problem-solving skills to resolve these issues in order to bring about changes in the lives of the care users.

4.3.3.2 Rehabilitation skills

Participants expressed the need to improve certain rehabilitation skills: specifically skills that concerned the identification and implementation of suitable activities. The participants described the rehabilitation *skills needed to communicate with mental health care users functioning at different levels, the identification of a relapse,* what to do when the *mental health care user has a lack of understanding of the activity;* what to do when *the nurses have a lack of understanding of an activity* and *sensory stimulation.*

Skills needed to communicate with mental health care users functioning at different levels are necessary in order for these care users to understand what is expected of them so that appropriate rehabilitation can be implemented and then the expected outcomes will be met.

Verbal communication must be used appropriately by ensuring that messages are clear, brief and measured; short sentences should be used; the nurse should supply direction instead of always asking questions; steps for activities or tasks should be given one at a time, and the nurse needs to allow enough time for the mental health care user to respond to any question or statement made (Middleton, Uys & Macera 2010:501-502). Interactions, including communication, must focus on stimulating the awareness of the mental health care user's own body, to stimulate sensory and motor systems (De Witt 2005:23). Routines, activities and procedures should be explained at the level of understanding of the individual. Nurses should communicate and explain what is being done and why it is being done at the level of functioning of the individual. The purpose behind an explanation is to decrease anxiety by preparing the individual for what is to happen in the future (Barry 2002:74). In line with this are the participants' descriptions of how they communicate with care users on different levels. Each care user is an

individual with different needs, and different outcomes need to be met; therefore, specific communication skills need to be applied.

A further rehabilitation skill that emerged from the discussions was how to *identify a relapse of a mental health care user*. The understanding of the causes was an important aspect discussed, as well as the importance of identification in order to implement care, treatment and rehabilitation. The literature states the importance of identifying a relapse, as well as stating specific causes, whereas the participants only discussed knowing the causes as important but did not specify any of these causes.

Different variables can be related to a relapse and could include health, environment and attitude or behaviour. Health could involve poor nutrition; lack of sleep; infection; medication or lack of exercise. The environment plays a role in a relapse if it is hostile; pressure to perform on the part of the mental health care user; a change in life events such as divorce, or loneliness. Low self-concept; hopelessness; lack of confidence; lack of control; the feeling of being overwhelmed by symptoms of illness; poor socialisation skills and poor medication compliance can be affected by attitude or behaviour (Uys 2010b:279-280). According to Wolfson et al (2009:16, 24) schizophrenia is a relapsing illness and has risks of suicide, self-neglect and harm to others, which increases the person’s vulnerability; therefore it is important for the healthcare professionals to have skills in relapse prevention.

The participants described what should be implemented when a *mental health care user does not understand the activity.* In order to make the activity understandable by the care users, they would ask other nurses and the care users questions and assess the level of understanding of the care user. They also described what they would do when *the nurses themselves have a lack of understanding of an activity.* They described how they would ensure understanding by discussing the activity with another mental health care professional.

The role of the psychiatric nurse has changed from that of providing custodial care to the dynamic approach of providing care during the rehabilitative process. A psychiatric nurse provides therapeutic, preventative and promotive psychotherapy and assists the multi-disciplinary team with therapeutic and rehabilitative activities (Neeraja 2008:46-47). The psychiatric nurse needs recreational skills in order to distract the mental health

care users by using their time constructively during leisure activities. The nurse needs to ensure that opportunity is given for the care user to improve attention span; follow rules or norms; relax the mind; have fun and enjoyment; improve interest in daily activities; be involved in a balanced daily programme; actively participate and improve concentration (Neeraja 2008:70).The participants discussed the importance of nurses' understanding of activities; the literature explains that the nurse needs to initiate the activities; this in turn will allow the nurse to have greater understanding of the activities. Helpful literature is available.

The activity of *sensory stimulation,* which is implemented with the low-level functioning care users, requires specific skills on the part of a nurse to ensure it is implemented correctly.

Sensory stimulation uses vision, hearing, touch, taste and smell in order to assist in a person's mental functioning and understanding of the environment around him or her. It is used to help people with learning difficulties, sensory impairment and dementia; it encourages interaction and communication, and decreases stress and boredom. Sensory stimulation aims to promote relaxation and encourage positive behaviour and emotions (National Health Service 2011). Concurring with the literature, the participants described what sensory stimulation entails: stimulating all the senses and memory, as well as the rehabilitation skills needed to implement it.

4.3.4 Means of communication within psychiatric rehabilitation

Communication in psychiatric rehabilitation is an important part of therapeutic intervention. Interpersonal skills that are used are essential in helping the person who is experiencing mental health problems. Many appropriate and effective communication skills need to be implemented by a psychiatric rehabilitation practitioner (Morrissey & Callaghan 2011:1).

4.3.4.1 Verbal communication

According to the discussions and descriptions given by the participants, the nurses communicate verbally with the mental health care user.

Talking to the mental health care users forms part of verbal communication and allows the nurses to gain information from the care users in order to implement rehabilitation according to their individual needs.

Verbal communication through talking allows for clarification of understanding or pointing out important aspects of a conversation. Talking assists the anxious or easily distracted care user to concentrate on what is being discussed. Giving information involves giving facts and health education, orientation and instructions for group activities (AntaiOntong 2007:71-72). However, the participants discussed talking as verbal communication in order to gain more information from the care users, rather than the nurses' giving information. The literature also confirms the importance of talking within the psychiatric setting.

The participants gain further information from the care users through *asking questions,* which also assist in assessing the care users' level of function and behaviour. This information allows for the planning and implementation of appropriate rehabilitation.

Questioning is an important communication tool, as it builds understanding and trust and encourages shared decision making. Health information concerning the care user assists the nurse in understanding experiences, likes and dislikes and the needs of the mental health care user (AntaiOtong 2007:76). The participants' statements accord with the literature, in that the nurses ask questions concerning the mental health care users' health and experiences.

Allowing expression of feelings gave the participants an opportunity to understand the care users' problems and feelings in order to implement appropriate care, treatment and rehabilitation.

Expression of feelings is a significant part of therapy of mental health care users and it is important for nurses to encourage them to express their feelings in a way that is not destructive and is acceptable to the individual, such as writing, talking and drawing. The nurse needs to ask the mental health care user what methods he or she has used in the past or what he or she has done to express feelings (Schultz & Videbeck 2009:27). The participants, however, discussed expression of feelings through verbal means and not

through writing or drawing, but they did ask questions in order to assist users to express their feelings, as supported by the literature.

The participants said that they *interviewed the mental health care users* individually in order to gain further information, as well as using this as a means to deal with problem behaviour and allow them to express how they were feeling without other care users around to interrupt.

According to Carniaux-Moran (2008:41), an interview is a conversation with a specific purpose that is accepted by the people involved. The purpose of the interview is to collect information that is needed to treat and understand the patient as well as to provide a safe environment. This literature source discusses reasons for interviewing, such as present functioning, the identification of feelings and obtaining specific information about the care user, such as the history of the individual. These reasons were also discussed by the participants.

Interviewing allows the nurse to obtain a history of how the mental health care user functions on a biological and social level and any previous psychiatric treatment the care user has been taking; what the user's present functioning is. This assists the nurse to identify problems, behaviour and feelings of the mental health care user (Pietersen & Middleton 2010:199-200).

4.3.4.2 Non-verbal communication

During the focus groups it emerged that the participants used various forms of non-verbal communication to communicate with the mental health care users. *Therapeutic touch* was described by the participants as a form of non-verbal communication used with the mental health care users. "The way they touch the care users' hands" is how they described it.

According to Mauk (2010:679), therapeutic touch is the movement of the nurse's hands over the body of the mental health care user in order to balance the energy fields. Both physical touching and non-contact touch are involved, non-contact touch is all about the movement over the individual person's energy field. The purpose of therapeutic touch is

to transfer the life energy from the nurse's hands to the mental health care user, who in turn uses the energy to restore health.

The theory of therapeutic touch results from the idea that universal life energy sustains all living creatures and that health is compromised when an imbalance occurs in the energy flow. Therapeutic touch is a process that involves the patterning of the mental health care user and environmental energy fields (Carpenito-Moyet 2008:243). The statements made by the participants indicate a very different understanding of therapeutic touch from that stated in the literature above, in that the participants only felt it involved touching the mental health care user's hands, and no mention was made of energy fields. The literature describes it in a broader, more holistic manner, whereas the participants described it practically and emotionally.

Listening to the mental health care users shows care and concern for them and the participants described the importance of active listening as a form of non-verbal communication.

Listening allows the nurse to learn about the experiences of the mental health care user. Active listening is not easy, but the nurse must keep focus when listening (O'Carroll & Park 2007:18). Active listening is the basis of all interactions. The nurse will find it difficult to assess the mental health care users' needs, requests or concerns unless time is taken to listen to them. Active listening involves understanding, interpreting and taking a genuine interest in the point of view of the user. Listening is an interactive and ever-changing process, with all the senses being used in order to pick up on verbal and non-verbal cues (AntaiOtong 2007:58). The literature indicates the importance of listening as non-verbal communication, as did the participants during the focus groups, especially as regards understanding the care user and showing their care and concern for the care user.

Certain mental health care users at the psychiatric rehabilitation centre are deaf or hard of hearing, and therefore non-verbal communication in the form of *sign language* is a need, according to the participants. The use of sign language allows the appropriate rehabilitation to be implemented according to the needs of the care users.

Changes in hearing and sight influence communication due to external stimuli and how people respond. Devices are often needed that improve failing sensory function, including prescription spectacles and hearing aids. Communication with the hard of hearing requires patience and sensory-enhancing strategies, such as speaking loudly, but not yelling; pausing for responses and using touch appropriately (AntaiOtong 2007:25). People with a hearing impairment often use a combination of lip reading, sign language and amplification in order to understand what is being said (University of Washington 2013). The latter source discusses, among strategies for other impairments, different means of communicating with hard-of-hearing people that include sign language, a knowledge of which was discussed by the participants as a need in order to communicate with these care users.

Descriptions were given by the participants of *communication by low level functioning mental health care users.* Many of these users are unable to speak and therefore use gestures and other non-verbal cues, such as pointing, to communicate with the nurses. The participants described the need to understand these gestures and non-verbal cues.

Mental disorders cause impairments of attention, concentration, and cognitive and communication function due to damage or deficits in the frontal cortex of the brain. Mental disorders such as schizophrenia, depression, attention deficit/hyperactivity disorder (also known as ADHD) and obsessive-compulsive disorder are linked with changes in frontal lobe function. Alzheimer's disease is also associated with damage to or deterioration of the frontal lobe and other brain regions, which causes sensory-perceptual disturbances such as hallucinations and delusions, as well as problems with speech, therefore affecting verbal and non-verbal communication (AntaiOtong 2007:15).

According to Stancliff, Larson, Auerbach, Engler, Taub and Lakin (2010:87, 90) a study was performed in 26 states in the United States of America (US) on augmentative and alternative communication (AAC) used by adults with intellectual disabilities and the way they responded to interview questions. The results of the study showed that adults with intellectual disabilities communicated mainly by natural speech; those who used a non-speech means of expression used mainly gestures or body language. Some used sign language or finger spelling, and the lowest number used aided AAC. This source discussed how communication is affected by mental disorders and how low-level

functioning users communicate by means of gestures and other non-verbal cues. The descriptions of the participants were in line with this.

4.3.4.3 Written communication

The participants stated that writing skills are needed in order to write down records of the mental health care users. The participants discussed the *importance of record keeping* in order for nurses to communicate with one another about changes in the care users' behaviour and what was happening with each care user.

In a health care facility, the nurse is the health care professional mainly responsible for the records of the mental health care user; these records include information on health care and the response of the user to the medical and nursing care. The information needs to be recorded as a chronological story concerning the care user's progress, allowing for continuity of care. The purpose of keeping records includes ensuring proper communication between health care professionals regarding the care user's health status and progress. It also involves planning of care, which depends on the comprehensiveness of the information obtained (Geyer 2007:7-8). Record keeping provides information on how care is provided through assessment, identifies problems and expected outcomes once care is implemented and planning for discharge. Concept mapping is being used more and more in order to decrease the amount of paperwork for a nurse, which should improve the nurses' critical thinking and reasoning skills (Ballard 2008:30).

Written communication encompasses observations made, the analysis of information obtained concerning the mental health care user, interventions performed and the evaluation of the interventions; the records are needed to support any decisions made so that new plans of care can be implemented (Geyer 2009:98).

These literature sources support the views of the participants concerning the importance of written communication, though the participants did not emphasise its importance as much as the literature does. Alternatives to report writing such as concept mapping were not discussed by the participants, but they did include in their statements certain aspects that need to be recorded, such as family contacts and behaviour of the care user.

The participants also discussed *monthly reports* recording evaluation of progress of the care user. Barker (2004:44) states that the aim of writing a report, especially after an interview, is to have something to look back on, to remind the nurse of what took place and what was said, in order for more thought to be given, for a conclusion to be reached on what to do, as well as to be able to discuss the interview with other members of the team. This supports what was discussed by the participants concerning information reported, such as specific interventions implemented, even though the participants were discussing reports written on a monthly basis.

4.4 EMERGING RELEVANT OUTLIERS

In Chapter 3, mention was made of outliers that were identified as important but did not fit in with any of the categories, sub-themes or themes. These outliers revolved around the nurse as a psychiatric nurse. Uys and Middleton (2010:837) state that psychiatric nursing is a speciality found within the nursing profession whereby the nurse promotes mental health, prevents mental illness, ensures the prompt identification of, and intervention in emotional issues and implements follow-up care in order to reduce any long term effects of mental illness.

The participants described the special role they had as psychiatric nurses and the professional pride they took in being a psychiatric nurse, which in turn resulted in positive feelings about psychiatric nursing. According to the literature, positive nursing should always be one of the qualities portrayed by a good nurse. Research studies indicate that negative thinking and negative emotions such as depression, fear, panic and frustration can have negative effects on human health and the way the nurse delivers care (Scala 2013). According to Neeb (2006:36), all nurses need to practise in an ethical manner, resulting in their having pride in their profession and feelings of respect towards the profession.

The feelings that the nurses have concerning their work affects the knowledge and skills they use in order to implement the rehabilitation process. The positive feelings that emerged in these nurses will allow them to implement the knowledge and skills they possess and to continue improving their knowledge and skills for the benefit of the mental health care users.

4.5 CONCLUSION

The chapter discussed the descriptions and views expressed by the participants during the focus groups in relation to the themes, sub-themes and categories identified by the data analysis, and identified and presented relevant literature supporting these discussions and descriptions.

Chapter 5 presents an overview of the study, and discusses the conclusions drawn, limitations that occurred during the study and recommendations made. A continuing professional development plan is designed.

CHAPTER 5

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

Chapter 4 presented the data that had emerged from the focus groups and compared them with supporting literature under the themes and sub-themes that had emerged from the data analysis. This chapter presents an overview of the study, conclusions and limitations of the study and makes recommendations in relation to the findings. It also presents an outline of a continuing professional development plan for nurses who practise in the mental health care environment.

5.2 OVERVIEW OF THE STUDY

The purpose of the study was to gain an in-depth understanding of the knowledge and skills about rehabilitation of mental health care users of nurses who work at a psychiatric rehabilitation centre, in order to design a continuing professional development plan for registered and enrolled nurses.

The objectives of the study were to

- explore and describe the knowledge and skills of nurses regarding rehabilitation of mental health care users
- develop a continuing professional development plan for nurses on rehabilitation in a psychiatric setting

The study used a qualitative, exploratory descriptive design in order to explore the knowledge and skills of nurses who practise in a psychiatric rehabilitation centre.

5.3 FINDINGS AND CONCLUSIONS

Based on the findings presented in Chapter 3 and the literature review in Chapter 4, it is concluded that nurses at the psychiatric rehabilitation centre do possess some knowledge and understanding of the rehabilitation process, principles of communication and implementation of rehabilitation. However, the participants expressed a need for more knowledge on the management of mental illnesses and the mentally ill, and confirmed that these needs could be met through a continuing professional development plan. Although the participants were from two different categories of training they fulfil the same role with regard to rehabilitation. It could be concluded that the differences in levels of training could have an effect on the knowledge of participants.

5.3.1 The rehabilitation process

Nurses saw their role in the rehabilitation process as important and one that facilitated change in users' lives, empowering them to return to the community to function at their optimal level. The participants agreed on the importance of treating mental health care users undergoing rehabilitation with respect and dignity. The participants emphasised assessment of users in order to plan and implement appropriate activities on each individual's level of functioning, so that individual rehabilitation could take place. Participants had some knowledge about individual and group activities within the psychiatric setting, and acknowledged the role of the multi-disciplinary team in the implementation of rehabilitation.

Participants highlighted the importance of a therapeutic relationship involving trust, respect and dignity, and of knowing the care user by relating to his or her cultural and spiritual beliefs.

5.3.2 The need for continuing professional development

The study found a need for further knowledge on specific aspects relating to mental illnesses:, the behaviour displayed in relation to a specific mental condition, the management of different types of mental illnesses, including substance abuse, and appropriate activities for those who functioned at a low level. Participants were

concerned about safety issues at the rehabilitation centre and expressed a need for professional development to address issues that threatened their safety at work.

5.3.3 Nursing skills required for the implementation of psychiatric rehabilitation

The skills regarded as important for nurses to implement for rehabilitation include the following: interpersonal skills such as listening, patience (specifically in relation to the low-level functioning individuals), empathy, observation skills in order to plan and implement appropriate rehabilitation and to identify a relapse, and problem-solving skills to deal with the variety of problems that mental health care users experience. In addition nurses expressed a need for communication skills, particularly to communicate with low-level functioning care users and during various rehabilitation activities.

5.3.4 Means of communication within psychiatric rehabilitation

The participants in this study expressed various needs in connection with verbal and non-verbal communication. They needed interviewing skills to gain information and allow care users to express their feelings and needs. Active listening, and learning the appropriate use of touch within psychiatry were identified as needs. They would like to be able to use sign language as a communication skill. They emphasised the importance of recording (written communication) in mental health care users' files.

The researcher has devised a continuing development plan which could add to nurses' knowledge and competence within psychiatry and rehabilitation, thereby assisting them to meet the needs of the care users through appropriate care, treatment and rehabilitation.

5.4 LIMITATIONS OF THE STUDY

The following limitations of the study were noted by the researcher:

- The study was conducted in one psychiatric rehabilitation centre. As the purpose of the study was not to generalise the findings, a similar study in another psychiatric rehabilitation centre could yield other findings.

- Nurses on night duty did not participate in the study although they sometimes have to implement rehabilitation for the mental health care users when they work day shift.

5.5 RECOMMENDATIONS

Based on the findings, the researcher makes the following recommendations for further research, nursing education and nursing practice.

5.5.1 Further research

It is recommended that further research be conducted on the following topics:

- A quantitative study to determine the knowledge and skills of registered and enrolled nurses at other psychiatric rehabilitation centres within the hospital group. This could provide a different perspective on nurses' knowledge about rehabilitation. It is recommended that a quantitative study be done to determine whether nurses have the knowledge and skills to implement rehabilitation for mental health care users.
- Research on the perceptions of enrolled nursing auxiliaries about their role in the rehabilitation process at the psychiatric rehabilitation centre. This could provide information on their role in rehabilitation and their needs for training.
- Research at psychiatric rehabilitation centres that have commenced with a continuing professional development plan for nurses practising rehabilitation. This could help by evaluating the effectiveness of a continuing professional development plan.

5.5.2 Nursing education

This study found that there is a need for further knowledge within nursing on psychiatric nursing skills, management of the mentally ill, management according to the different mental illnesses and rehabilitation activities.

It is recommended that:

- Training departments within psychiatric rehabilitation centres or hospitals should devise their own continuing professional development plan in relation to the knowledge and skills needs of their nurses. This would enable nurses practising in a psychiatric setting to develop further as psychiatric nurses.
- Practical assessment tools should be devised to measure the knowledge and skills competency of the nurses in relation to the continuing professional development plan. The assessment should be a means of acknowledging their strengths and improving areas where they might be lacking. The outcome should be competent nurses within a psychiatric setting.

5.5.3 Nursing practice

It was found that during nursing practice in the wards, certain rehabilitation and psychiatric nursing skills were not being implemented due to a lack of knowledge and skills. Such skills related to management of care users, their illnesses and behaviour, and choice of activities according to level of functioning.

It is recommended that:

- A continuing professional development plan be implemented at psychiatric rehabilitation centres.
- Unit managers encourage nurses to attend CPD programmes.
- The role of experienced psychiatric nurses as role models is strengthened.

5.6 CONTINUING PROFESSIONAL DEVELOPMENT PLAN

A continuing professional development plan allows for the implementation of specific activities that meet the needs of the nurses and bring about change in order to achieve goals and outcomes (Alsop 2013:37).

An outline of a proposed continuing professional development plan has been designed to address the needs of nurses at a psychiatric rehabilitation centre.

Table 5.1 Outline of a continuing professional development plan

Topic	Sub-topic
1 Knowledge about the behaviour exhibited by people who suffer from specific mental conditions	• Manipulative behaviour • Display of aggression • Behaviour exhibited by the intellectually disabled
2 Management of mental illness	• Therapeutic environment • Therapeutic use of self • Behaviour modification
3 Substance abuse by mental health care users	• Abuse of snuff – causes, effects and management • Alcohol abuse – causes, effects and management • Dagga abuse – causes, effects and management
4 Specific rehabilitation activities	• What do rehabilitation activities involve? • Activities performed in the occupational therapy department • Activities specific to each individual • Activities specific to the different levels of functioning
5 Management of mental health care users functioning at a low level	• Intellectual disability – care and management of different categories (i.e. mild, moderate, severe and profound) • Group activities specific to users functioning at a low level • The special needs of the low functioning care users as regards care, treatment and rehabilitation
6 Safety of staff members	• Management of aggression presented by mental health care users • Conflict management between care users

5.7 CONCLUSION

This study explored the knowledge and skills of nurses about rehabilitation of mental health care users. It was found that nurses did have some knowledge and understanding of the rehabilitation process within the psychiatric setting, but the study identified areas where knowledge was needed.

The South African Nursing Council may recommend the commencement of CPD within hospitals and psychiatric rehabilitation centres; the findings of this study indicate that nurses within a psychiatric setting have specific needs. All nurses have a responsibility to keep up to date and to remain competent in their field of work, but the psychiatric rehabilitation centre has a particular responsibility to the care users, to ensure that their nurses are competent, knowledgeable and skilled.

The study is important for nurses within a psychiatric rehabilitation centre because a CPD plan designed specifically for the nurses would allow them to keep up to date with psychiatric and rehabilitation knowledge and skills. The up-to-date knowledge and skills would ensure that the mental health care users receive care, treatment and rehabilitation at the hands of knowledgeable, skilled and competent nurses.

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Annexure 1

Information leaflet given to the participants

Annexure 2

Informed consent for participants

Annexure 3

Letter requesting permission to conduct the research study

Annexure 4

Permission letter from the hospital manager

Annexure 5

Permission letter from the College Senate Life Healthcare

Annexure 6

Department of Health Studies, Higher Degrees Committee, Unisa: Ethical Clearance Certificate

Annexure 7

Co-coder report

Annexure 1: Information leaflet given to the participants

1. Research study method: Qualitative research will be conducted which allows for exploration and probing in order to get in depth information.
2. Purpose of the research study: To gain an in-depth understanding of the knowledge and skills of the registered and enrolled nurses at the psychiatric rehabilitation centre regarding rehabilitation of mental health care users so that a continuing professional development plan can be developed.
3. Risks and benefits:It is not envisaged that participants will suffer any discomfort, or negative side-effects due to participation in the study. Benefits include gaining understanding of knowledge and skills needed for rehabilitation.
4. The researcher will go into the environment where the research is totake place i.e. the psychiatric rehabilitation centre
5. Time commitments of the participants: Participation in focus groups which will not interfere with on duty time.
6. Right to withdraw from the research study at any time choose to
7. The types of questions that may be asked during data collection: What knowledge and skills regarding rehabilitation are important and needed for nurses working with mental health care users in a psychiatric rehabilitation centre like you are working in?
8. How the results of the research will be used: Develop a continuingprofessional development plan.
9. How the anonymity of the participants concerning the results will be ensured: Any identifiable information will be removed once the focusgroups have been verified and the researcher is certain no further information is needed from the participants. Taped focus groups which could identify the participants will be stored in a secure place and once the study has been completed this data will be disposed of.
10. Participation and information provided by the participants during the focus groups will be kept confidential.

Annexure 2: Informed consent for participants

I confirm that I have been informed by Mandy Perry about the study to be undertaken.

The study has been explained to me and I understand what is involved in the study.

I understand that I may at any stage of the study, withdraw my consent and participation in the study without any prejudice.

I have been given sufficient opportunity to ask questions and I am prepared to participate in the study.

I therefore acknowledge and accept my participation in the study.

Name: ________________________________

Signature: ____________________________

Date: _________________________________

Annexure 3: Letter requesting permission to conduct the research study

40 Donegal Villas
Donegal Road
Kenmare
Krugersdorp
1739
18 September 2012

Hospital Manager
West Rand Complex
28 Maughum Road
Randfontein
1760

Dear Mrs Mbatha

I am currently completing my Masters' degree at the University of South Africa. The focus of my dissertation is on the *Comprehensive approach to continued professional development of registered and enrolled nurses at the psychiatric rehabilitation centre.*

I require the registered and enrolled nurses working in the wards, to assist me with obtaining data. I will be involving them in focus groups in order to obtain the data needed. The research study will not keep the registered and enrolled nurses from their work duties. I hereby request your permission to conduct this research study.

I will be seeking permission from the Life Healthcare Nursing Research Committee in order to conduct the research at the West Rand Complex.

The results of the research study will be used to contribute to the enhancement of rehabilitation through a continued professional development plan.

Yours sincerely

Mandy Perry

Annexure 4: Permission letter from the hospital manager

Randfontein Care Centre
Old South Compound, Randfontein Estate Gold Mine
28 Maugham Street, Randfontein 1759
PO Box 319, Randfontein 1760
Telephone: +27 11 693 3615/6
Telephone: +27 11 693 5243/4
Telefax: +27 11 412 3510
www.lifeesidimeni.co.za

26 September 2012.

Mandy Perry

40 Donegal Villas

Donegal Road

Kenmare

Krugersdorp

1739

Dear Mandy,

In response to your letter dated 18 September 2012, I would like to inform you that I am granting you permission to conduct your research in our Facility.

I am positive and believe that your research will add value and contribute greatly to the enhancement of Rehabilitation program within Life Esidimeni.

Should you need assistance or have any queries feel free to contact me.

Yours Sincerely,

Mrs J.Mbatha.

Hospital Manager

Life Esidimeni (Proprietary) Limited
Reg. no. 1982/000915/07
Directors: SD Mbele (Managing), RJ Hogarth, PJ Jaure, DL Lenong

Annexure 5: Permission letter from the College Senate Life Healthcare

Life Healthcare Head Office
Oxford Manor, 21 Chaplin Road, Illovo 2196
Private Bag X13, Northlands 2116, South Africa
Telephone: +27 11 219 9000
Telefax: +27 11 219 9001
www.lifehealthcare.co.za

Life Healthcare group (Pty) LTD is registered as a
Private Higher Education College with the DHET
Registration number: 2008/HEO7/003

05 October 2012

ATTENTION: MANDY PERRY

APPROVAL FOR RESEARCH STUDY
TITLE: Comprehensive approach to continued professional development of registered and enrolled nurses at a psychiatric rehabilitation centre.

Our previous correspondence refers.

The Research Committee of the Life Healthcare College of Learning has granted permission for your study.

We look forward to seeing the results of your research once it is completed.

Yours sincerely

Anne Roodt
Nursing Education Specialist

Life Healthcare Group (Proprietary) Limited
Reg. no. 2003/024367/07 Registered address Oxford Manor, 21 Chaplin Road, Illovo 2196, Private Bag X13, Northlands 2116
Directors: Prof GJ Gerwel (Chairman), CMD Flemming (Managing Director), RJ Hogarth (Financial Director),
MA Brey, Dr MP Ngatane, GC Solomon

Annexure 6: Department of Health Studies, Higher Degrees Committee, Unisa: Ethical Clearance Certificate

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

HSHDC/77/2012

Date of meeting: 7 August 2012 Student No: 3007-244-1

Project Title: Comprehensive approach to continued professional development of registered and enrolled nurses at a psychiatric rehabilitation centre.

Researcher: Mandy Jacqueline Perry

Degree: MA in Health Studies Code: DIS702M

Supervisor: Prof MJ Oosthuizen
Qualification: D Litt et Phil
Joint Supervisor: Prof GH van Rensburg

DECISION OF COMMITTEE

Approved [√] **Conditionally Approved** [ ]

Prof D van der Wal
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

Dr MM Moleki
ACTING ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

Annexure 7: Co-coder report

<u>Co-coding of research</u>

Process of co-coding

Recorded focus groups was listened, and correlated with the transcriptions. Descriptive coding technique was used for organisation of the data (Burns & Grove, 2008:522).

The following themes were identified in the data:

Communication skills

- Two clearly defined categories: for high functioning and low functioning patients.
- Skills staff identified: Assertiveness, Conflict management, Listen
- Trust relationship with patient
- Trust relationship with staff to support each other

Knowledge

- Indication of type of CPD needed: Participants responsible for own knowledge-practical (adult learning)
- Specific gaps identified where knowledge required: Substance abuse, Handling of addictions, Aggression and Inappropriate behaviour
- Respecting patients cultures/religion/beliefs

Assessment of patients

- Observation of changes in patient behaviour to look out for (risks)
- Individual and group activities
- Therapeutic touch/ Sensory stimulation

Family education

- Assistance of patient to prevent relapse
- Support in Community

Ensuring personal safety of staff

- Group activities/ counselling for staff to build confidence, manage stress and stay motivated.

Recreational activities

- Candle making
- Money skills
- Mending of shoes
- Sport

I hereby declared that all the data was treated with confidentiality, and anonymity.

Heleen Brink

RN RM MCur