REGISTERED NURSES' EXPERIENCES IN MANAGING PATIENTS DIAGNOSED WITH DEPRESSION IN A GENERAL MEDICAL WARD

by

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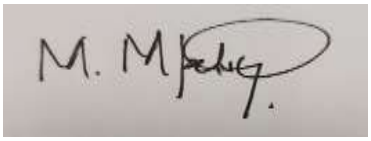
DECLARATION

I declare that **REGISTERED NURSES' EXPERIENCES IN MANAGING PATIENTS DIAGNOSED WITH DEPRESSION IN A GENERAL MEDICAL WARD** is my own work and that all sources I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.



25 November 2022

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SIGNATURE **DATE**

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ABSTRACT

Protecting and restoring mental health is of direct concern to the public and health professionals, especially nurses, who are often patients' first point of contact with the health system. This study sought a comprehensive understanding of registered nurses' experiences managing patients diagnosed with depression in a general medical ward. The study followed a qualitative research design. Data were collected using in-depth face-to-face interviews with participants recruited from two general medical wards of a private hospital in Gauteng province. Data were analysed thematically.

The findings indicated that detecting depression on admission or during a hospital stay in a general medical ward is problematic for registered nurses. Nurses had little training or experience in psychiatric nursing. Patient acuity tools limited available staff, resulting in poor patient evaluation and care. Nurses found hospital management unsupportive and faced the COVID-19 pandemic as an additional challenge that increased their vulnerability. The nurse-patient relationship was compromised due to social distancing, increased staff shortages, patient mortality and death anxiety, and a lack of protective clothing. Nurses feared contracting the COVID-19 virus from patients admitted with COVID-19. Patients had death concerns and suffered additional burdens due to the social restrictions caused by COVID-19 regulations.

The rate of depression has increased worldwide and is expected to continue as natural disasters and health problems increase. To address this mental health crisis, the shortcomings of the mental health system must be addressed.

Key terms

COVID-19; depression; diagnosed; experience; general medical ward; mental health; physical illnesses; registered nurses.

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DEDICATION

I dedicate this study to Prof Jeanette Maritz, my research supervisor from the University of South Africa, who has taught me everything about the research I have used in this dissertation.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
CDC	Center for Disease Prevention and Control
COVID-19	Corona Virus Disease of 2019
HIV	Human Immunodeficiency Virus
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
PPE	Personnel Protective Equipment
SANC	South African Nursing Council
US	United States
WHO	World Health Organization

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

The rate of depression has increased globally, showing remarkable shortcomings in the mental health system (Dardas 2021:1). Winkler, Formanek, Mlada, Kagstrom, Mohrova, Mohr and Csemy (2020:6) posited that a rise in mental health problems creates an additional weight for mental health stability and causing difficulty in closing existing intervals in the management of patients with mental health challenges. Mental health has been a public health concern for many years, as prevalence affects individuals' physical and social well-being as well as cause a high economic burden for society (Marcus, Yasamy, Van Ommeren & Chisholm 2012:4). During, and in the wake of the Coronavirus Disease of 2019 (COVID-19) pandemic, mental health issues have escalated and are now a crisis in public health ((Moreno, Wykes, Galderisi, Nordentoft, Crossley, Jones, Cannon, Correll, Byrne, Carr, Chen, Gorwood, Johnson, Karkkaineh, Krystal, Lee, Lieberman, Lopez-Jaramillo, Mannikko, Phillips, Uchida, Vieta, Vita & Arango 2020:813). 2020:814).

Strauss, Macdonald, Ruiz, Raugh, Bartolomeo and James (2021:17), stated that the Coronavirus disease of 2019 resulted in mental health problems such as anxiety and depression worldwide, although not yet measured accurately. Protecting and restoring mental health is of immediate concern to the public and other health professionals, especially nurses, who are often patients' first point of contact with the health system (Serrano-Ripoll, Meneses-Echavez, Ricci-Cabello, Fraile-Navarro, Fiol-deRoque, Pastor-Moreno, Castro, Ruiz-Perez, Zamanillo Campos & Goncalves-Bradley 2020:347). Wada, Rajwani, Anyam, Karikari, Njikizana, Srour and Khalid (2021:10) stated that it is imperative that every nation's government policymaker, as well as international organisations, execute proposals for improved, attainable, and economical mental health services to improve the mental health status of the population. Mental disorders are found in a large proportion of the global population, putting pressure on people of all income levels, including patients with physical illnesses in a general medical ward (Rehm & Shield 2019:1).

The World Health Organization [WHO] (2020) defined depression as a significant cause of unfitness worldwide and is an utmost supporter of the overall ailing disease burden. Depressive disorders, such as depression, are among the most critical public health concerns, as they have become the leading disease burden and disability globally and in South Africa (Nglazi, Joubert, Stein, Lund, Wiysonge, Vos, Pillay-Van Wyk, Roomaney, Muhwava & Bradshaw 2016:48). Depression is a common disease condition in the world, with more than 264 million people affected (WHO 2020:2). Nglazi et al (2016:48) found that depression is amongst the top three causes of disease burden worldwide. Nguse and Wassenaar (2021:305) highlight that in South Africa, mental disorders have been overlooked by the health system. One out of six people have been diagnosed with depression, anxiety, or a substance use disorders, 40% of South Africans living with HIV have depression comorbidity, 41% of women are depressed in their pregnancy, and 60% of South Africans are subject to post-traumatic stress. Strikingly, only about 27% of South Africans diagnosed with mental disorders receive treatment.

There are various types of depression, such as major depression, persistent depression, manic or bipolar depression, depressive psychosis, perinatal depression, a premenstrual dysphoric disorder, seasonal depression, situational depression, and atypical depression (Pietrangelo 2018:1). For this study, the focus was on major depression (further referred to as depression). Major depression is a condition that is characterised by fluctuating moods with feelings of worthlessness and not showing interest in existence. Depression affects a person's eating habits, sleeping patterns, feelings, and thoughts about life (Kraus, Kadriu, Lanzenberger, Zarate & Kasper 2019:2). The presence of symptoms of depression for two weeks or more in a patient leads to a diagnosis of major depression (Kerr 2020:2). Shumye, Belayneh and Mengistu (2019:1) highlight that the burden of depression can lead to poor quality of life for patients diagnosed with depression and their loved ones, and prevention, psychosocial support, prompt diagnosis and early treatment of patients diagnosed with depression are suggested to reform the quality of life of individuals diagnosed with depression. According to the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) (2017), a significant number of patients found in a general hospital with physical conditions often have depression. Patients with severe depression often develop physical illnesses a decade earlier in their lives than other people (NCEPOD 2017). Davis and Lockhart (2017:26) posit that registered nurses often meet patients diagnosed with depression in a general medical ward. This is contrary to

the belief that individuals diagnosed with depression are only found in psychiatric institutions.

Pinkert, Faul, Saxer, Karrer, Burgstaller, Kamleitner and Mayer (2017:1) supported that patients diagnosed with depression are often found in general medical wards, and it is still unclear how registered nurses in general medical wards manage patients with depression. Furthermore, Poncelet (2020:1) mentioned that at its worst, depression can give rise to suicidal thoughts and other critical medical conditions such as cardiovascular failure.

If unresolved, patients diagnosed with depression in general medical wards will remain poorly managed. Minty, Moosa and Jeenah (2021:8) stated that unfortunately, not all patients diagnosed with depression in a general ward receive proper management, compared to patients admitted with physical illnesses. The poor management of patients diagnosed with depression in the general medical ward could also result in poor management of physical conditions. Muir (2017:48) noted that there is a tendency for general ward registered nurses to overlook or neglect patients diagnosed with depression when they are admitted. The registered nurses' late detection and misunderstanding of depression are associated with reduced quality of care and survival of patients with depression.

Schuch and Stubbs (2019:300) stated that due to the individual and societal load of depression, there is an urgent need for different perspectives for preventing and managing depression. Therefore, registered nurses were invited to discuss their experiences about managing patients diagnosed with depression in a general medical ward. This chapter will further outline the problem statement, the purpose and research questions, and a short overview of the research methodology and ethical implications.

1.2 RESEARCH PROBLEM

Mental health is essential to physical health (Galea 2019:1). Physical well-being tends to receive priority attention and resources due to higher mortality rates (Galea 2019:2). The most crucial part of healthcare rendered to patients with mental health problems occurs in general medical wards (Muir 2017:48). While working in a general medical ward, the researcher observed that registered nurses routinely deliver care that focuses on patients'

physical illnesses but pays little or no attention to their mental health status. The researcher observed that patients with depression are often underdiagnosed or unidentified on admission and, if identified later, are poorly managed. The nursing documentation guidelines of the hospital do not include the assessment of depression and management during admission, their hospital stay, and upon discharge. These observations have similarly been noted by Muir (2017:49).

In informal conversations between the researcher and the general medical ward registered nurses, it emerged that registered nurses perceive that nurses in general hospitals concentrate on the physical management of illness and that attending to patients diagnosed with depression is not part of their scope of practice. The registered nurses in a general medical ward said that they feel they are ‘not psychiatric nurses’. Al-Awadhi, Atawneh, Alayan, Shahid, Al-Alkhadhari and Zahid (2017:32) posited that many psychiatric patients in a general hospital experience discrimination by healthcare professionals such as registered nurses and doctors. Alshahrani (2018:1) added that as healthcare professionals, registered nurses display more negative attitudes towards patients with depression than the public does, resulting in poor quality of care.

A study by Damane (2018:5) found that several registered nurses failed to regard depression as a severe problem. Instead, these nurses think that patients with depression do not deserve the same caring with compassion, dignity, and respect as other patients. Pols, Schipper, Overkamp, Van Dijk, Bosmans, Van Marwijk, Adriaanse and Van Tudler (2017:1) found that patients with chronic medical problems in a general medical ward stand a higher chance of being depressed as they are also isolated from their families, friends, and relatives. Against this backdrop, registered nurses’ late detection and misunderstanding of depression are related to the poor quality of life and survival of patients diagnosed with depression. Mulango, Atashili, Gaynes and Njim (2018:6) highlighted an inadequate practice in diagnosing and managing patients with depression in general hospitals. The current belief in managing patients diagnosed with depression in a general medical ward still reveals a lack of quality.

Taquet, Geddes, Husain, Luciano and Harrison (2020:132) posited, that COVID-19 also contributed to psychiatric disorders such as depression. Patients who contracted COVID-19 had a doubled risk of being diagnosed with depression. Most of the recoveries from COVID-19 were later diagnosed with depression for the first time in their lives. Daly and

Robinson (2022:518) added that patients who had previously been diagnosed with depression had a high chance of being diagnosed with COVID-19. Gao and Tan (2021:199) urged registered nurses managing patients diagnosed with depression in a general medical ward, to show their dedication to caring for and maintaining a satisfactory environment in meeting the patient's mental and physical health needs while adhering to COVID-19 rules and regulations of social distancing, and to apply the personal protective equipment to protect the patients from COVID-19.The effects of COVID-19 needed registered nurses in a general medical ward to be able to manage patients diagnosed with depression adequately. Literature mainly concentrates on physicians, clinicians, consultation-liaison psychiatrists, psychiatrists, psychiatric nurses, and psychiatric hospitals when addressing depression (Muir 2017:49). This author indicates that registered nurses in general medical wards are, however, often the first contact point with patients; they have a greater responsibility in the early intervention process of depressed patients. The mental health status of patients should be attended together with physical health, and helpful services should be provided.

When depression becomes the underlying issue on admission to a general medical ward, registered nurses need skills and confidence to manage the patient holistically. According to Harris (2018:2), hospital systems still lack adequate training for registered nurses to care for patients who happen to be depressed while admitted in a general medical ward. This could result in registered nurses lacking the confidence in caring for patients diagnosed with depression in a general medical ward.

1.3 PURPOSE OF THE RESEARCH STUDY

This study seeks an in-depth understanding of registered nurses' experiences managing patients diagnosed with depression in a general medical ward.

1.4 RESEARCH OBJECTIVES

The objectives of the study were two-fold. The research intended to:

- Explore and describe registered nurses' experiences in managing patients diagnosed with depression in a general medical ward.

- Identify potential opportunities for improving the nursing management of patients diagnosed with depression in a general medical ward.

1.5 RESEARCH QUESTIONS

This study seeks to find answers to the following two questions:

- What are registered nurses' experiences managing patients diagnosed with depression in a general medical ward?
- What can be done to improve the nursing care of patients diagnosed with depression in a general medical ward?

1.6 SIGNIFICANCE OF THE STUDY

This study will potentially add to the body of knowledge of registered nurses' experiences regarding the treatment of patients diagnosed with depression in a general medical ward. On a practical level, this understanding could potentially assist nurses and unit managers in rendering optimal and holistic patient care to patients diagnosed with depression on admission or during hospitalisation in a general medical ward.

1.7 DEFINITION OF CONCEPTS

1.7.1 Registered nurse

A registered nurse is a person who has obtained a nursing qualification and is competent to practice nursing independently in a certified manner and takes full responsibility and accountability for acts and omissions (South African Nursing Council [SANC] 2005:25). In this study, a registered nurse is a nurse who qualifies, according to the SANC, to treat and manage patients.

1.7.2 Experience

Experience is a direct contact and observation of activities or facts (Roth & Jornet 2014:108). In this study, experience refers to registered nurses' direct contact and

observation of activities or facts of patients diagnosed with depression on admission or developing depression during hospitalisation in a general medical ward.

1.7.3 Patient diagnosed

A diagnosis is a term given to the disease or a condition associated with the presenting signs and symptoms of a particular patient (Rakel 2022). In this study, the presenting signs and symptoms of major depression should be present. The patient should be diagnosed with depression on admission or develop depression during hospitalisation in a general medical ward.

1.7.4 Depression

Depression is a condition characterised by fluctuating moods, feelings of worthlessness, and a loss of interest in life. Depression affects a person's eating habits, sleeping patterns, feelings, and thoughts about life (Kraus et al 2019:2). Symptoms of depression must be present for no less than two weeks for a patient to be diagnosed with major depression. In this study, 'diagnosed with depression' means diagnosed with major depression on admission to the general medical ward or during their period of hospitalisation.

1.7.5 General medical ward

A general medical ward refers to a block forming a division of a hospital, or a suite of rooms shared by patients who need a similar kind of care (Gray 2022). In this study, a general medical ward refers to a ward with persons admitted with the diagnosis of acute and chronic medical conditions that may also include depression on admission or developed during hospitalisation.

1.8 RESEARCH PARADIGM

Every scholarly body of research is undertaken following a worldview or paradigm. This is so whether the researcher declares the research paradigm followed or not. Several research paradigms exist, including positivism, realism, and an interpretive paradigm

(Kumatongo & Muzata 2021:30). In this light, this study followed the naturalistic interpretive paradigm.

Attention was paid to understanding the individuals and the explanation of their views of the world around them (Kivunja & Kuyini 2017:33). Qualitative research is embedded in the interpretive approach to social phenomena and the interpretation of lived human experiences. According to Brink, Van der Walt and Van Rensburg (2018:19), interpretivism affirms the seriousness of participants' perspectives in understanding social phenomena. Researchers should be able to make meaning of their data through their thinking and cognitive processing of data obtained through the interaction with the participants. Interpretivism believes that there is an unavoidable intercommunication between the researcher as the interviewer and the study participants. The researcher and the participants blend and listen as they hold dialogues with each other.

In this study, registered nurses managing patients diagnosed with depression in a general medical ward are regarded as most appropriate to describe their own experiences. In the interpretive paradigm, truth and knowledge are based on an individual's lived experiences and how the individual understands those experiences (Ryan 2018:41). It is impossible to remove researchers from their values and beliefs that would influence how data is collected, interpreted, and analysed. The interpretive paradigm seeks a deeper understanding of the topic under study and permits an account of people in their own social context (Pham 2018:3). In this study, the social context is the general medical ward, where registered nurses experience managing patients diagnosed with depression. This study, as being interpretive, relied on qualitative data. The researcher seeks an in-depth understanding of the subject matter, which is the experiences of registered nurses in managing patients diagnosed with depression in a general medical ward.

Through the interpretive paradigm (Creswell & Poth 2018:6), scholars could delve deeper into the research inquiry, collecting and collating interviewees' thoughts, perceptions, views, feelings, and perspectives regarding the management of patients with depression in the general medical ward. As this is a qualitative research study, the researcher collected the data from the participants over an extended period. The interpretive paradigm aims to understand social circumstances from the participants' perspective.

The study participants, the registered nurses managing patients diagnosed with depression in a general medical ward, were given a chance to express their experiences. The social interaction was accepted from the viewpoint of the registered nurses and not the researcher. In this study, the social phenomenon of interest is the registered nurses' experiences managing patients diagnosed with depression in a general medical ward. The selected paradigm fits a qualitative research design, the design chosen to guide the research.

Rehman and Alharthi (2016:55) stated that researchers are entirely part of the social context being researched. The goal of the interpretive research paradigm is to understand social realities from the viewpoint of the participants. In this study, the researcher's purpose was to understand the experiences of managing patients diagnosed with depression from the perspective of registered nurses in a general medical ward. In the interpretive paradigm, the data analysis follows the inductive approach and not the deductive approach, so that theory should arise from data collection rather than the other way around.

1.9 RESEARCH DESIGN AND METHOD

The following section will describe an overview of the research design and methods.

1.9.1 Research design

This study followed a generic qualitative design (Percy, Kostere & Kostere 2015:76). Combining exploratory and descriptive aspects provided a broad and in-depth view of the area of inquiry. This was the design of choice because the researcher saw it imperative to obtain a detailed understanding of the experiences of registered nurses in managing patients diagnosed with depression in a general medical ward.

1.9.1.1 Research setting

The study occurred in two general medical wards of a selected public, private hospital in Gauteng province. Gauteng is the name given to one of the nine Republic of South African provinces. Gauteng province is the smallest province in South Africa, but it is the most crowded and occupied by more than a quarter of the South African population. The

province is also regarded as the wealthiest province in South Africa. The private hospital is in the central city of Krugersdorp. Krugersdorp, also known as Mogale City, is one of the three local municipalities of the West Rand District in Gauteng province. According to Community Survey (2016), the population of Mogale City was 363 864 at that time.

Mapukata (2019:2) found some districts with as high as 58% to 76% of residents reporting regular episodes of depression and loss of interest in life in Gauteng province. The hospital has 265 beds. It comprises of the emergency department, theatres, intensive care units, high care units, COVID-19, paediatric, general and orthopaedic wards, and a cardiac catheterisation unit. There is also a neonatal intensive care unit, maternity section, radiology department, and laboratory services.

The hospital employs permanent staff with certain affordances for specialised units such as intensive care units and general wards such as the medical ward; the registered nurses and the rest of the staff are accepted with knowledge and experience in nursing science. Some registered nurses might have psychiatric nursing as part of their qualifications, but it is not the main requirement for a general medical ward nurse. General medical wards are wards that often admit patients diagnosed with depression on admission or during hospitalisation. The hospital consists of two general medical wards.

1.9.1.2 Population

The study population consisted of all professional nurses who are permanently employed in the general medical wards of the selected hospital. Twelve registered nurses worked in the two general medicals ward during the research study period.

1.9.1.3 Sample and sampling

The sample contained the whole population and therefore no sampling was done. Although all 12 nurses were invited only ten participated in the study.

1.9.1.4 Data collection

Polit and Beck (2021:510) highlighted that in qualitative research, the fundamental method of data collection is by interviewing participants. This study collected data through

in-depth interviews, and field- and reflective notes. In-depth interviews were a suitable data collecting method because it permitted the researcher to obtain a greater in-depth understanding than other methods would have allowed. Ten interviews were conducted and took proximately 45 minutes each. Two participants declined the participation in the study. The gathering of data was done until the different participants brought no new information but repeated the same information, meaning that data saturation was reached (Hennink & Kaiser 2022:1). According to Phillippi and Lauderdale (2018:381), field notes are one of the forms of record-keeping in the qualitative study, meaning only factual information is documented. Field notes provide an assessment of the research study findings by interpreting the data across qualitative data corpuses.

Reflective notes in the qualitative research study propel the researcher to take time and reflect on their performance both as an interviewer and a participant (Phillippi & Lauderdale 2017:384). Reflexivity implies looking back and deep into oneself and checking personal beliefs that could influence the gathering of information and interpretation (Polit & Beck 2021:156). In this study, the researcher acknowledged that she was familiar with the study setting and some employees, and reflected on her prejudice, intolerance, or unfairness during the data collection and analysis through a reflective diary and debriefing interviews with the supervisor before- and during data collection and data analysis. A detailed description is presented in Chapter 3.

1.9.1.5 Data analysis

Data analysis in qualitative studies requires a review of content, not numbers, as in quantitative research (Brink et al 2018:180). In this study, thematic data analysis occurred concurrently with the data collection and was analysed through a thematic approach. Data analysis will be detailed in Chapter 3.

1.9.2 Measures of trustworthiness

In any qualitative research study, researchers must attain trustworthiness (Hayashi, Abib & Hoppen 2019:98). Trustworthiness is defined as the conviction that qualitative researchers have in their collected data (Polit & Beck 2021:493). Amin, Nørgaard, Cavaco, Witry, Hillman, Cernasev and Desselle (2020:1475), described the principles of rigour, including credibility, confirmability, dependability, and transferability were applied.

1.9.2.1 Credibility

The confidence in the reality of the data and its interpretation is its credibility (Polit & Beck 2021:493). Qualitative researchers are required to ensure the truth of the findings of a participant. Credibility was ensured by collecting information from registered nurses managing patients diagnosed with depression in a general medical ward.

- **Prolonged engagement:** The researcher spent one year with the participants before the interviews, the period whereby the researcher learned the general medical ward culture and gained a better understanding of registered nurses' behaviours and work relationships. The participants were then invited to the interviews, where the researcher spent 30 minutes with each participant to obtain the consent to participate in the study, and 30 minutes prior to the interviews to build trust, create rapport and understand the views of the registered nurses and 45 minutes during the interviews. There was no need for follow-up interviews.
- **Triangulation:** Diverse views were obtained by interviewing until data saturation was reached. The literature consulted also included diverse views and discourses.
- **External checks and member checking:** The participants examined, explored, and challenged the transcripts to check if their experiences were accurately represented in the transcripts. No changes were required.
- **Reflexivity:** The researcher exposed the biases, values, and experiences brought into the study, starting at the onset of the study by keeping a reflective diary. By bracketing these aspects, the researcher ensured that her background, personal values, and position in the general ward had limited influence on the study.
- **Peer review:** In this study, the researcher invited other registered nurses working through an agency in the same general ward but were not study participants. These peers were allowed to ask questions regarding the methods used and conclusions to expose the researcher's biases in the study (Creswell & Poth 2018:261).

1.9.2.2 Dependability

Polit and Beck (2021:493) highlighted that dependability is the information that can be trusted to be true even after a period of time, and under all circumstances. The researcher was responsible for ensuring that the study was done to address the problem statement.

- **Inquiry audit:** An audit trail involving tracking and recording all decisions was used to influence the study so that an outside individual could examine the data based on the paradigm adopted in this study. Relevant annexures are also added to the dissertation.
- **Description methodology:** A thick description clarified how the data was generated and analysed.
- **Co-code procedure:** An external co-coder with whom a confidentiality agreement was set, assisted in the co-coding of the data. The co-coder was given a set of clean data. A consensus discussion was held after the researcher and the co-coder independently coded the data. The supervisor monitored the coding proses.

1.9.2.3 Confirmability

Confirmability is defined in terms of the following two aspects:

- **Confirmability audit:** In this study, a confirmability audit was conducted at the same time as the inquiry audit by the study supervisor. Data, findings, interpretations, and recommendations were reviewed to ascertain if the data supported the study.
- **Chain of evidence:** The researcher provided an audit trail as a chain of evidence.

1.9.2.4 Transferability

Transferability describes how the qualitative findings can be transferred elsewhere (Polit & Beck 2021:493).

- **Thick description:** refers to the in-depth and thoroughly described description of the research context and the processes observed during this study. This was done for the study to be replicated (Polit & Beck 2021:493).

1.10 ETHICAL CONSIDERATIONS

Researchers need to consider what ethical issues are found during the study and plan how to address these issues to embed ethical study practices (Creswell & Poth 2018:63). In this study, the researcher considered all critical ethical issues while planning,

designing, and executing the study as the human participants were involved. In this vein, the researcher considered the Belmont Reports' primary ethical principles (Czubaruk 2019:2). Ethical clearance and permission to carry out the research study were granted by the University of South Africa's Department of Health Studies (Annexure A). Permission to conduct the research was requested and obtained from the Organisation's Research Operations Committee (Annexures B and C).

The participants were invited, and the researcher explained that their participation in the study was voluntarily. The participants were provided with enough information leading to an informed decision to participate in the research study. The ethical principles of beneficence, justice, respect for people, and informed consent were respected from the beginning to the end of the study and will be detailed in Chapter 3.

1.11 SCOPE OF THE STUDY

The scope of this study was limited. The study was done according to a particular purpose with a specific population in mind: registered nurses at a given location and geographical area. The study was conducted from 20 January 2020 to 20 October 2022, following a qualitative design and methods.

1.12 THE CHAPTERS

The chapters in this study are presented as follows:

- Chapter 1: This chapter lays out the introduction, research problem, research objectives, significance of the study, research questions, and definition of key concepts. An overview of the research paradigm, research design, methods, and ethical principles are provided.
- Chapter 2: This chapter shares the understanding of other literature related to the phenomenon under study.
- Chapter 3: The chapter will discuss the research design and methods.
- Chapter 4: This chapter will present the research findings.
- Chapter 5: The chapter will discuss the recommendations, limitations and conclusions of the study.

1.13 SUMMARY

This chapter presented the introduction, research problem, the purpose of the study, research objectives, the contribution of the study, and the definition of key concepts. The chapter further discussed the research paradigm and an overview of the research design and methods. Lastly, this chapter explained the trustworthiness of the study and clarified the ethical considerations, concluding with an outline of the chapters.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

A literature review is necessary for the researcher to understand the work of other researchers on the subject under study, as well as documentation, integration, and evaluation of the confirmation of a research study problem (Polit & Beck 2021:82). The researcher searched for sources from the Internet, abstracts from dissertations, and journals, and books from the library, and used Google Scholar, Wiley Interscience, PubMed, Science Direct to review the literature. The literature first presents a broad overview of depression as a condition, the prevalence of depression in general hospitals, depression and related physical conditions, depression and cancer, depression and Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), depression and cardiovascular diseases, depression and diabetes mellitus.

Focusing on the scope of this study, the review also discusses the literature dealing with depression and COVID-19, suicide on a general medical ward, its effects on patient quality of life in a general medical ward, direct effects on patient quality of life, and issues related to the health system with respect to the management of patients diagnosed with depression in a general medical ward. The review also discusses the contribution of registered nurses to the quality of life of patients diagnosed with depression in a general medical ward, stigma and depression in a general medical ward, self-awareness of registered nurses, nursing assessment of patients diagnosed with depression in a general medical ward, planning and implementation of nursing management of such a patient in a general medical ward, and exploring the gaps in the treatment of depression in a general medical ward.

2.2 DEPRESSION

Pietrangelo (2021:1) explained that depression is an extensive spectrum of mental health problems distinguished by a lack of positive impact and interest in life matters. Depression also results when a person consistently thinks negatively about self, individuals are

persistently in a low mood, and have less interest in life (Chand & Arif 2022:4). Depression can be cured, but sometimes recovery is incomplete, or a patient can easily relapse (Kakrani 2020:1). Min, Jon, Jung, Hong, Song, Kim, Harkavy-Friedman, Im and Hong (2021:1147) highlighted that in its worse state, depression can cause an individual to have thematic symptoms with remorsefulness, rejection feelings of and can be aggressive towards others. They may also feel suicidal. Depression results in emotional effects, such as the feeling of being useless and unimportant or that one is not contributing to the group that one belongs to. Keller, Leikauf, Gosselin, Staveland and Williams (2019:279) explained, that patients with depression might also have cognitive dysfunction that is characterised by a diminished capacity to reason and focus. Some of the patients diagnosed with depression in the general medical ward also develop cognitive impairment symptoms such as poor concentration and poor attentional processes (Sinha, Arora, Srivastava & Klein 2022:2).

Some people cannot do their jobs, resulting in a loss of family income. Depression and chronic physical conditions have been established to be strongly linked (Ohrnberger, Fichera & Sutton 2017:42). Physical conditions are referred to as chronic conditions because they last for an inordinately long time, are constantly recurring, and cannot be completely healed. However, it can be controlled by adjusting lifestyle elements, such as diet and compliance with medications (Lange & Nakamura 2020:146).

2.3 A PROFILE OF DEPRESSION IN SOUTH AFRICA

With a prevalence of 28.4%, depression in adults is a crucial public health challenge (Hu, Zhao, Wu, Li, Luo, Yang & Yang 2022:1). It also seems that there is increase in the prevalence of depression an overtime (Moreno et al 2020:813). Pillay (2019:464) highlighted that one in six South Africans goes through depression. In both low- and middle-income countries, the prevalence of depression is estimated at 80%. Only 10% of people diagnosed with depression receive proper treatment (Thornicroft, Chatterji, Evans-Lacko, Gruber, Sampson, Aguilar-Gaxiola, Al-Hamzawi, Alonso, Andrade, Borges, Bruffaerts, Bunting, De Almeida, Florescu, De Girolamo, Gureye, Haro, Hey, Hinkov, Karam, Kawakami, Lee, Navarroo-Mateu, Piazza, Posada-Villa, De Galvis & Kessler 2017:119).The exclusive burden of HIV/AIDS as a comorbid disease in South Africa has resulted in a high number of cases of depression. Mbili (2020:1) argued that people living with HIV/AIDS are more prone to depression than people who do not live with HIV/AIDS

and are 36 times more likely to commit suicide. The lifetime prevalence of depression in South Africa is approximately 9.7%, which is equivalent to 4.5 million people, and access to treatment for such depression remains a problem in both private and public facilities in South Africa (Motsoari 2021:1). In South Africa, a mental disorder is unfortunately not regarded as a priority in both the private and public sectors. Regrettably, 75% of people with mental disorders in South Africa do not receive mental health services, even when it is deemed necessary (Willie 2017:2).

2.4 PREVALENCE PERCENTAGES OF DEPRESSION IN GENERAL HOSPITALS

Gberie (2017:1) reported that about 33% of South Africans suffer from mental illness, and that about 75% of people diagnosed with mental conditions cannot access psychiatric institutions. These patients end up seeking treatment in general hospitals. Walker, Burke, Wanat, Fisher, Fielding, Mulick, Puntis, Sharpe, Esposti, Harriss, Frost and Sharpe (2018:2285) reported that depression commonly occurs along with chronic physical illnesses such as diabetes mellitus, increasing the prevalence of depression among patients in general hospital wards. Some patients can be identified and begin treatment for depression while admitted to a general hospital. Sick individuals present themselves more in general hospitals than in psychiatric institutions in South Africa. Several of the most prevalent chronic diseases that have a strong link with depression are highlighted below.

2.5 DEPRESSION AND RELATED PHYSICAL CONDITIONS

2.5.1 Depression and cancer

Depression occurs between 10% and 25% in people with cancer (Wondimagegnehu, Abebe, Abraha & Teferra 2019:1). Patients in general hospitals are often stressed as they try to adjust to the new diagnosis and the challenge of living with a chronic or deadly disease such as cancer. In a general medical ward, there are many patients admitted with different types of cancers. Some cancer patients are diagnosed for the first time in a general medical ward after several investigations were performed and find it difficult to adjust to the cancer diagnosis.

Cancer is also argued to be the most emotionally challenging event that brings depression to an affected individual. The prevalence of depression among cancer patients is higher than among people in the general population; it ranges from 16.4% to 66.72% (Barak, Tessema & Demeke 2020:2). Szelei and Döme (2020:908) highlighted that depression decreases the recovery rate of cancer patients. The relationship between advanced cancer and depression is strong. People with cancer tend to feel more pain, and pain leads to depression; as pain intensifies, depression also intensifies. Woo, Song, Lee, Joo, Kim, Kim, Han, Park, Kim and Lee (2019:79) urged that pain management should be essential to prevent depression in cancer patients. Depression in people diagnosed with cancer is mainly influenced by healthcare costs, access to healthcare facilities, and access to disability grants, as cancer hurts an individual's financial status (Niedzwiedz, Knifton, Robb, Katikireddi & Smith 2019:3).

In some cases, the diagnosis of cancer is delayed and leads to depression because the patient may not want to accept the condition; they feel hopeless, especially when the prognosis is poor. The increased risk of depression should be considered during the diagnosis and treatment of patients with cancer in a general medical ward. Cancer and depression can be insidious (Naser, Hameed, Mustafa, Alwafi, Dahmash, Alyami & Khalil 2021:7). The mortality rate of patients with cancer and other physical diseases is high; depression sets in after diagnosis. Patients diagnosed with cancer as a co-morbidity with the diagnosis of depression have an increased risk of suicide (Choi & Park 2019:815).

2.5.2 Depression and Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)

HIV/AIDS is realised as a leading co-morbidity in patients with depression (Girma, Assegid & Gezahegn 2021:1). The literature has shown that depression and HIV/AIDS are interlinked. Admission of patients to a general hospital due to depression is more common in patients HIV on antiretroviral therapy (ART) (Ngum, Fon, Ngu, Verla & Luma 2017:103). There is a strong link between depression and HIV positive diagnosis. The WHO (2008) also stated that HIV/AIDS leads to an obvious psychological burden.

In a general medical ward, patients with HIV/AIDS are admitted regularly, and some patients are only finally diagnosed with HIV/AIDS during admission to a general medical ward. Patients become depressed after such a recent diagnosis. There are also

behavioural risk factors among patients with depression, such as non-adherence to antiretroviral medications and unprotected sexual intercourse, which accelerates the spread of HIV/AIDS (De Moraes & Casseb 2017:743). The high prevalence of depression in patients with HIV leads to a failure to comply with ART, and consequently delays the recovery process in general hospitals. There is no evidence that appropriate care is provided for patients with depression and HIV/AIDS in a general medical ward. Registered nurses are often found to be incompetent and scared for their own lives when managing patients with depression with an HIV/AIDS diagnosis in such a ward (De Moraes & Casseb 2017:743). On the World Health Day, the WHO (2017) revealed that there is a high possibility that people living with HIV/AIDS may abort treatment if good measures to treat mental health are not put into practice. Effective treatment for patients diagnosed with depression is necessary as it also helps to treat co-morbidities such as HIV/AIDS. Integrated facilities for HIV/AIDS and depression in all countries must help healthcare personnel in their fight against HIV/AIDS and depression.

2.5.3 Depression and cardiovascular diseases

Depression is one of the main factors in general hospital admissions among patients with chronic diseases such as cardiovascular diseases (Engidaw, Wubetu & Basha 2020:2). Chauvet-Gelinier and Bonin (2017:6) posited that people with cardiovascular diseases develop depression more than the general population. Cardiovascular diseases result in high mortality in people diagnosed with depression in a general medical ward. At the same time, people with depression are more prone to cardiovascular diseases than those who are not depressed.

The severity of depression determines the survival rate of patients with cardiovascular disease. Chauvet-Gelinier and Bonin (2017:8) highlighted that there is a link between depression and chronic cardiac failure. In a general medical ward, registered nurses treating patients with depression are expected to monitor the cardiovascular status of patients for early detection and prompt management of cardiovascular diseases as well. Cognitive hostility must be assessed to avoid resulting in cardiovascular mortality. Depression can reduce the patient's cognitive ability. People diagnosed with congestive cardiac failure are also at increased risk of depression. The combination of chronic illnesses and depression causes self-isolation, which worsens depression.

2.5.4 Depression and diabetes mellitus

People diagnosed with diabetes have an increased chance of experiencing depression (Jovinally 2018:1). More risk factors lead to the development of depression in patients diagnosed with diabetes mellitus in a general medical ward than in the general population. People diagnosed with depression tend to have more physical illnesses than those without it; they often have worse experiences when admitted to a general medical ward (Foye, Simpson & Reynolds 2020:406). Depression that occurs together with physical conditions is even worse when poorly diagnosed than depression that occurs on its own. Barhum (2020:1) stated, that chronic physical illnesses cause a higher rate of depression. Registered nurses tend to focus on diabetes mellitus because it is a common medical diagnosis. Treatment of depression in the same patient is usually left unattended. Poor holistic approach to the patient delays recovery from both diabetes mellitus and depression in a patient in a general medical ward. Depression in patients with diabetes mellitus causes poor personal care.

According to Dare, Bruand, Gerard, Marin, Lameyre, Boumediene and Preux (2019:2), comorbidities such as depression and chronic physical diseases are a real burden for people of all income levels. Depression is often associated with chronic illnesses, and this worsens the patient's health status (Dare et al 2019:2). In patients with diabetes, depression is seen more often than in the general population. A physical condition such as diabetes mellitus can complicate the assessment and treatment of depression in a general ward, as it confuses the symptoms of depression (Sharif, Raza, Mushtaq, Afreen, Hashim & Ali 2019:11).

2.5.5 Depression and coronavirus disease of 2019 (COVID-19)

The implications of COVID-19 on depression could not be left unattended; the disease became a global pandemic and took the lives of millions of people around the world. Panchal, Kamal, Cox and Garfield (2021:4) highlight that the COVID-19 pandemic hurt the mental health status of many people. Patients diagnosed with COVID-19 were often found with depression in a general medical ward (Taquet et al 2020:130). Some patients developed depression fourteen to ninety days after a diagnosis of COVID-19 in a general medical ward (Taquet et al 2020:130).

Van der Velden, Hyland, Contino, Von Gaudecker, Muffels and Das (2021:2), categorised depression due to COVID-19 into three levels:

- **Micro-level:** At this level, people were afraid to be infected or to have their family members and significant others infected. Those who had infected family members became even more depressed, as they were not sure if their sick family would recover. They were not even allowed to visit them at the hospital. Social distancing and quarantine resulted in depression in people infected and affected. Depression was aggravated by the loss of jobs by the breadwinners due to some companies closing or retrenching some staff members.
- **Meso-level:** At this level, people became depressed from the closing of gatherings during the lockdown. People enjoy themselves in groups, whether for religious gatherings, weddings, or even funerals. The preventive rules and regulations of COVID-19 isolated people in a large way.
- **Micro-level:** At this level, depression was brought about by job insecurity. The collapse of the economy leads to an increase in prices for consumers. The health facilities had a shortage of essential equipment such as ventilators and oxygen apparatus. At the micro-level, hospitals had a shortage of nurses and beds. The mortuaries were overflowing with human bodies. Some countries have made mass graves.

Stress and concerns about COVID-19 infection caused some people to suffer from insomnia, indulge in alcohol, and other aggravating chronic conditions. Lack of access to health facilities for consultations and visits to sick family members, relatives, and friends resulted in depression in the families of patients. Individuals with a poor general health status reported more symptoms of depression than individuals with a good general health status (Panchal et al 2021:4). The economic burden due to lockdown regulations led to the loss of jobs in all countries and made people who were already depressed have even less access to healthcare facilities (Nunez, Sreeganga & Ramaprasad 2021:1).

People could watch their significant others get infected, become extremely sick, and in some instances, lose their lives. Individuals were isolated from their families in quarantine centres or hospitals with COVID-19 wards and intensive care units.

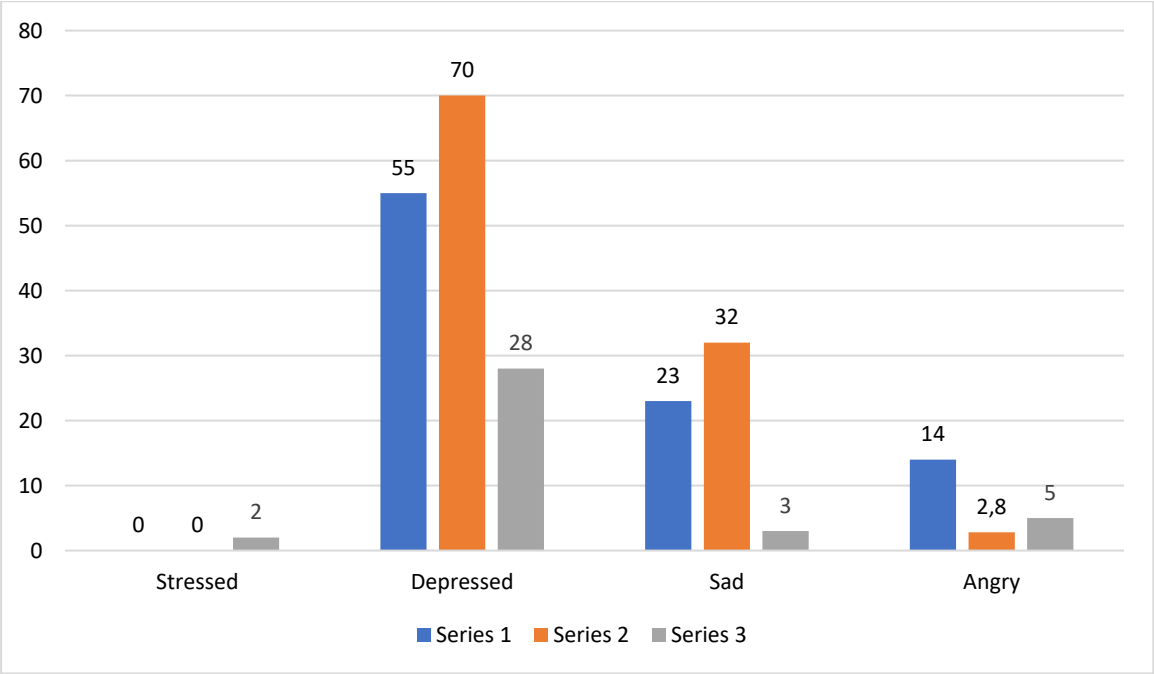

Figure 1.1 COVID-19 impact amongst South Africans

(Orkin, Roberts, Bohler-Muller & Alexander 2020)

Healthcare workers, especially those working on the frontline, did not escape the negative consequences of stress exposure and fear of infecting themselves or their loved ones. Women were more affected than their male counterparts. They also experienced a lack of social support and training that resulted in maladaptive coping strategies and depression (Moreno et al 2020:815).

2.6 DEPRESSION AND SUICIDE IN A GENERAL MEDICAL WARD

Research shows that there is a strong association between depression and suicide in general wards. Most suicide victims have a history of depression that results in loneliness or self-isolation. Patients can still commit suicide due to depression after discharge (Bradvik 2018:2).

Depression is rated as the leading mental disorder that leads people to die by suicide (Bradvik 2018:3). Depression is the main cause of suicide deaths in South Africa and worldwide and failure to diagnose and treat depression results in suicide (Bachmann 2018:1425). Resources necessary to raise awareness about suicide in South Africa are lacking. Matandela and Matlakala (2016:55) highlighted that a specific healthcare facility

had at least four patients in four years who successfully committed suicide during their admission period in a general medical ward.

Matandela and Matlakala (2016:3) posited that patients often commit suicide in general medical wards even when admitted for physical illnesses, resulting in serious injuries and even death. When patients die by suicide in a general medical ward, registered nurses are also affected. Depression is detrimental to the health of people and should be addressed as soon as it has been identified, as it is often linked to suicide (Winerman 2017:81).

2.7 EFFECTS OF DEPRESSION ON THE QUALITY OF LIFE FOR PATIENTS IN A GENERAL MEDICAL WARD

2.7.1 Direct effects of depression on patient quality of life

It is not surprising that depression affects the quality of life of a patient (Ghoneim & O'Hara 2016:21). Razzak, Harbi and Ahli (2018:274) added that high mortality risk, poor outcomes of treatment of physical disorders, and poor quality of life in hospitalised patients are associated with depression. In an Akeso media release, Mazibuko and Foot (2021) stated that patients diagnosed with depression are as legitimately ill as patients with physical illnesses, but they do not receive enough support, have fewer intervention alternatives, and often do not receive the value of care; both in their communities and in general hospitals.

Allocation of resources, such as human and material resources, also does an injustice to patients with depression as to those with physical illnesses (Sabin & Daniel 2021:1). The acuity tool of the medical staff on a general medical ward is created to accommodate more nursing staff so that special attention is given to patients diagnosed with depression in a general medical ward. Approximately 30 hours of work schedule should be allocated for the proper assessment, planning, and implementation of care of patients diagnosed with depression in a general medical ward. Winerman (2017:80) highlighted that depression is one of the most widespread and expensive ways to treat mental disorders. Depression is related to poor quality of life and patients diagnosed with depression with the potential to decrease quality of life should be recorded and assisted. Patients with depression may have impaired functioning with the development of comorbidities. Good

levels of nursing staff in nursing units result in minimum medico-legal hazards, less neglect of patients, more compassionate nurses, and an increase in the quality of nursing care (Haddad, Annamaraju & Toney-Butler 2020:2). For some patients in general hospitals, depression can lead to a decrease in interest in complying with medical treatment, with a subsequent delay in the recovery process. Individuals with a poor general health status reported more symptoms of depression than those with a good state. Depression could be a cause of distress and can have negative financial implications for the patient and family. Borglin, Rathel, Paulson and Sjögren Forss (2019:2) argued that depression is also linked to a high risk of death and suicide due to intellectual instability. In a general medical ward, depression is mostly accompanied by comorbidities, making it more difficult and expensive to manage.

2.7.2 Healthcare system-related issues regarding the management of patients diagnosed with depression in a general medical ward

Registered nurses can be seen as advocates for patients. They manage the quality of care in all healthcare facilities (Weldetsadik, Gishu, Tekleab, Asfaw, Legesse & Demas (2019:131). The impact of registered nurses on the quality of life of a patient in a general medical ward is determined by the availability of resources, knowledge and skills, perspectives, time, and their respect for a multidisciplinary team, patients and their families. The nursing management and hospital management team also play an important role in generating a suitable registered nurse work environment, with a therapeutic registered nurse-physician relationship that improves nursing care. Such an environment results in positive patient outcomes on a general medical ward (Weldetsadik et al 2019:134).

Patients with depression in a general medical ward are often prevented from a longer hospital stay due to financial implications. Patients diagnosed with other chronic medical conditions receive much attention and support. However, depressed patients are regarded as people who should take control of their illnesses and fix their own lives (Hollard 2022:1). Treating patients with depression is believed to be a burden in an already challenged healthcare system in South Africa (Johnston, Powel, Anderson, Szabo & Cline 2019:195).

2.7.3 Contribution of registered nurses to the quality of life of patients diagnosed with depression in a general medical ward

Healthcare personnel often are under the impression that the most appropriate action is to negate symptoms of depression and rather manage chronic physical conditions such as diabetes mellitus (Noblett, Caffrey, Debt, Khan, Lagunes-Córdoba & Gale-Grant 2017:28). On the contrary, Young (2018:34) argued that registered nurses in a general medical ward are expected to play a leading role in the early detection of depression and thereby, ensure early implementation of interventions that would lead to the improvement in the physical health of a patient. Proper documentation that includes the mental state of the patient is desirable for early detection and prompt management of depression. In fact, Munro and Milne (2020:22) also insisted that registered nurses are the front-line workers with the closest interaction with the patient and are expected to provide quality nursing care to patients diagnosed with depression in a general medical ward.

Giandinoto, Stephenson and Edward (2018:942) argued that most health professionals perceived patients with depression as dangerous, compared to patients with physical illness. Their perceptions are due to their limited exposure, lack of skills, and poor mental health knowledge. Such perceptions could result in negative attitudes of some registered nurses towards people diagnosed with depression in general hospitals.

Registered nurses could become frustrated, dissatisfied with their jobs, and feel guilty and powerless (Mongrain & Shoikhedbord 2021:14). Gracie (2019:2) mentioned that an exception could potentially be those registered nurses who had personal experiences with depression themselves and may thus show compassion and empathy towards patients diagnosed with depression in a general medical ward. Young (2018:1) warned that registered nurses must recognise their personal biases to avoid missing signs and symptoms of depression in a patient.

Early detection and treatment of depression helps improve life, reduces mortality rates, leads to positive outcomes among patients, and can change the course of the disease (Razzak et al 2018:276). However, there is still a lack of clarity on the knowledge and attitude of registered nurses providing care to patients with depression in general medical wards in general hospitals (Ni, Guo, Chao, Wang, Susanty & Chuang 2020:2).

2.8 STIGMA AND DEPRESSION IN A GENERAL MEDICAL WARD

Unfortunately, stigmatisation behaviour exists among healthcare workers in a general medical ward (Knaak, Mantler & Szeto 2017:113). Depression also carries stigma to the patient and their family. Alshahrani (2018:5) corroborated such, indicating that one of the key areas where patients with depression experience stigmatisation, are in general hospitals. The stigma is associated with a lack of understanding and compassion for the patient with depression. Society lacks understanding of the needs and difficult times that patients suffering with depression experience. Some healthcare personnel may be under the impression that depressed patients are manipulative and uncooperative, difficult, and do not deserve the same quality nursing care as patients with physical illnesses (Knaak et al 2017:112).

Stigma delays the treatment and recovery of patients with depression. According to Alshahrani (2018:3), stigmatisation of depressed patients negatively affects the success of treatment for depression. Family members of depressed patients are also subjected to stigmatisation; they also suffer the negative impact of stigma (Yin, Li & Zhou 2020:141). It should be noted that both nurses and patients can be affected by their negative opinion of them. Other healthcare teams or units may show a lack of understanding for staff on the ward, as well as for patients. A patient with depression could already be under the impression that no one cares and may develop further negative feelings about life.

2.9 MANAGEMENT OF PATIENTS WITH DEPRESSION IN A GENERAL MEDICAL WARD

There are inequalities between the treatment of patients with physical conditions and patients with depression in general hospitals (Muir 2017:48). Patients with acute and chronic physical diseases have a higher chance of being diagnosed with depression while in a general medical unit than the general population. It is crucial to treat depression early to prevent the occurrence of other physical disorders. The appearance of physical conditions in patients with depression increases the mortality rate (Galea 2019:3).

Management of depression in a general medical ward includes the assessment of the physical and mental status of the patient by registered nurses and early identification of signs and symptoms of depression. Registered nurses should be aware of and recognise

the symptoms of depression in patients with physical illnesses on a general medical ward. Patients diagnosed with depression behave differently from patients with physical illnesses without depression. Blackburn, Wilkins-Ho and Wise (2017:172) emphasised that the detection of depression should be followed by highlighting predisposing factors, which can be newly diagnosed chronic illnesses or psychosocial factors such as bereavement. The researcher observed that in a general medical ward, it is most common for patients to receive their new diagnosis of chronic diseases after several diagnostic investigations are performed.

A new diagnosis of a chronic illness such as cancer or HIV/AIDS is a crucial moment in the life of a hospitalised patient. Sometimes a counsellor, a psychologist, or a family member is invited before breaking the news to a patient. After a registered nurse has made a diagnosis of depression, immediate referrals to the patient's primary physician are necessary. The primary physician should immediately refer the patient to a psychiatrist and other members of the multi-disciplinary team such as social workers and psychologists. After the diagnosis of depression, the psychiatrist will consider management options for a particular patient in a general medical ward. Depression medication should be administered by registered nurses as ordered by the physician. Treatment options should accommodate the physical illnesses of the patient, as some treatments for depression can work against the physical conditions of the patient in a general medical ward. Patients taking medication should be monitored for any side effects.

Sussman, Mccusker, Yaffe, Belzile, Sewitch, Cole and Strumpf (2016:183) stated that self-care management, support, and education as part of the collaborative activity by a multidisciplinary team can be ideal for the management of patients with depression in a general medical ward. Here, great face-to-face support can be offered to a patient diagnosed with depression. Registered nurses are the key people in developing the quality nursing care of their teams to manage patients diagnosed with depression in a general medical ward.

Family and friends should also be involved in the management of patients with depression in a general medical ward. COVID-19 rules have led to restrictions on visiting time in general hospitals, but family members can be assisted by members of the multidisciplinary team to make video calls to the patient diagnosed with depression.

Blackburn et al (2017:172) posited that antidepressants and cognitive therapy can reduce the symptoms of depression in a patient diagnosed with depression in a general medical ward.

2.9.1 Self-awareness of registered nurses

Registered nurses are in close contact with patients (Gao & Tan 2021:199). Their experience and dedication make it possible to manage patients diagnosed with depression and physical illnesses in a general medical ward. Registered nurses are patients' advocates and are pivotal in the construction of hospital policies to accommodate the need for ideal treatment of patients diagnosed with depression (Nsiah, Siakwa & Ninnoni 2019:1125). Hemberg and Gustin (2020:662) added that caring and compassionate nurses managing a patient diagnosed with depression, contribute to empirical patient outcomes and positive feedback from the patient.

Registered nurses are trained to focus on the total well-being of all patients. Mental health is part of the overall well-being of a patient. Registered nurses should be involved in continuous studies and scheduled unit in-services for the assessment and identification of patients with depression in a general medical ward. Nurses' respect for patient dignity and empathy can reduce the stigma attached to depression.

Munro and Milne (2020:18) stated that the ways registered nurses who manage patients diagnosed with depression can provide support as follows:

Registered nurses should understand that depression can subject both patients and their families due to social stigma and discrimination. Registered nurses should have an attitude that is non-judgmental towards patients and families. Registered nurses should be a beacon of hope and promote the recovery of patients. Provide patient-centered health and care practice that always respects patient dignity and support families of patients diagnosed with depression in a general medical ward. Registered nurses should continuously update family members on the condition of patients. Opportunities to visit patients more often are limited due to COVID-19 restrictions, but registered nurses should be able to connect with patient families through video and/or audio calls. The physical environment of patients in a general ward should ensure that self-injury is prevented, noise is low, and the environment is always peaceful.

2.9.2 Nursing assessment of patients diagnosed with depression in a general medical ward

Depression is quite common among patients admitted to a general medical ward, but depression is still undetected and poorly managed (Hantrakul, Wangsomboonsiri & Sriphrapradang 2020:22). General screening to exclude depression is not routine; as a result, there is a delay in detecting patients with depression by registered nurses (Hantrakul et al 2020:26). Most patients with depression are reluctant to discuss their mental status with physicians while in a general medical ward. The signs and symptoms of depression are dynamic. Only registered nurses who spend longer periods with the patient can detect them.

Registered nurses should have a one-to-one interaction with each patient in the ward and should be able to notice the change from physical illness to depression. A patient who has been diagnosed for the first time with a chronic disease such as cancer should be assessed by registered nurses for signs and symptoms of depression.

2.9.3 Planning and implementation of nursing management of a patient diagnosed with depression in a general medical ward

Thomas and Seedat (2018:24) highlighted that the planning and implementation of nursing management for a patient diagnosed with depression in a general medical ward as follows:

A registered nurse should create an atmosphere in which a patient diagnosed with depression in a general medical ward can interact with other patients and staff through communication and activities. The patient should only be put on isolation cubicles only if is necessary for infection control purposes. Patients' experiences should be examined, reactions modified, and hope encouraged. Comorbidities with depression and drug interactions for both conditions should be managed. Patients diagnosed with depression that are bedridden should be assisted with basic nursing activities such as bed baths.

The registered nurses should allocate enrolled nursing assistants to assist the patients and encourage grooming. Patients should be allowed to wear their pyjamas if possible. A registered nurse should observe the patient's eating habits, record intake and output, and

a pattern of bowel movements. Patients should be educated on the adherence to a healthy lifestyle. Patients may need a soft diet to avoid struggle with chewing. This should be followed by nutritional supplements such as milk formulas between meals depending on the patient's physical conditions. Some patients with depression in a general medical ward may have a voracious appetite and eat excessively. Meals should be scheduled and served in limited portions.

Praise the patient with depression for completing regular activities such as finishing a plate of lunch together with other patients. Registered nurses should be able to administer medication as prescribed and explain to a patient indication, side effects, and medication times. The medications ordered for depression should be administered along with the medications for physical illnesses. Open positive conversations with the patient. If the patient is overwhelmed with negativism, the patient can be given limited time, such as five minutes, to talk about negative issues and later divert to positive issues of life. Discourage a patient from concentrating on self-examination, towards being involved in pleasant and recreational activities, provide positive comments for cooperation. The general ward environment should always be less noisy to promote rest and sleep for a patient diagnosed with depression. Registered nurses should give feedback to the multidisciplinary team on the patient's prognosis for the diagnosis of depression.

2.10 EXPLORING THE GAPS IN THE MANAGEMENT OF DEPRESSION IN A GENERAL MEDICAL WARD

In healthcare facilities, there are serious limitations in screening for symptoms of depression and for prompt management of such. If screening for symptoms of depression were done and found positive, there would still be a delay in psychological intervention.

Assessment of the symptoms of depression is supposed to be a sixth vital sign in patients recently diagnosed with cancer. There is a lack of competence among physicians in identifying the symptoms of depression, and a delay in suggesting the need to identify screening tools to improve prompt diagnosis and treatment of depression in a general medical ward (Hallet et al 2020:1093). In fact, there is a need for global general hospital physicians, policymakers, and mental health stakeholders to acquire more successful programmes and routes to close the gap between the screening of patients for depression and the implementation of psychosocial interventions for patients prone to depression.

Depression should be the focus of sound clinical decisions, admission assessment protocols, and policies and guidelines on treatment options during hospitalisation to avoid complications in a general medical ward (Blackburn 2019:173). A review supporting the integration of mental health and physical illnesses in a general medical ward has found a lack of training among general nurses and other members of the multidisciplinary team on mental health problems (Ford 2017:1).

There are often patients in a general medical ward who need a referral to psychiatrists, but there are delays caused by patients' refusal to see a psychiatrist, administration delays such as transport arrangements to a psychiatric institution, and physician experiences (Turki, Babbah, Ouali, Ellouze, Abid, Charfi, Halouani & Alouou 2021:403).

Roy (2021:3) stated that there are hindrances to referrals from general medical wards to psychiatrists due to a lack of agreement between the other members of the multidisciplinary team and the psychiatrists, and difficulty in adjusting services to accommodate patients diagnosed with depression in a general medical ward. Fritz, Shenar, Cardenas-Morales, Jäger, Streb, Dudeck and Franke (2020:1) reported that some of the patients diagnosed with depression in a general medical ward would be aggressive, disruptive, and less compliant with nursing care. This causes a challenge for registered nurses, other members of the multidisciplinary team, and fellow patients. Registered nurses who manage patients diagnosed with depression, however, are comfortable when patients are sedated to keep them calm and unaware of their environment (Guttormson, Chian, Tracy, Hetland & Mandrekar 2019:256). Al-Dweik and Ahmad (2020:329) comment that patient acuity tools initially focused on the patient's physiological needs and failed to cover the patient's mental state, and failed reliability and validity testing.

2.11 CONCLUSION

A review of the literature is essential for quality nursing practice. It is through this literature review that a lack of knowledge is detected, and the researcher uncovers a need for further research on the topic. There is a paucity of studies on registered nurses' experiences regarding the treatment of patients diagnosed with depression in a general medical ward. Most studies revealed poor nursing management of patients diagnosed with depression in such wards. Previous studies that have detected that those patients

with mental health challenges such as depression in a general medical ward in general hospitals, claim that they tend to receive less care compared to patients with physical illnesses only. Current attitudes, preparedness, skills, and knowledge of general practitioners, such as nurses, were also noted, and a gap was identified that little or nothing has been done about this need.

CHAPTER 3

RESEARCH DESIGN AND METHODS

3.1 INTRODUCTION

This chapter outlines the research design and methods used to explore registered nurses' experiences managing patients diagnosed with depression in a general medical ward. This chapter will discuss the research design and tools used to collect data, how the data was managed and analysed, the ethical issues that arose during the study, and the necessary steps to address these. The purpose of the study was to gain an in-depth understanding of registered nurses' experiences managing patients diagnosed with depression in a general medical ward.

3.2 RESEARCH PARADIGM

A research paradigm is a technique of focusing on a natural occurrence in a worldwide view that leads the approach to a research study. The qualitative research approach follows an interpretivist paradigm. Interpretivism values subjectivity and inductive reasoning (Creswell & Poth 2018:33).

3.3 RESEARCH DESIGN

A research design is a comprehensive plan for acquiring the desired response to the research questions (Polit & Beck 2021:51). This study followed a generic qualitative design, combining exploratory and descriptive aspects to provide a broad and in-depth view of the area of inquiry (Percy et al 2015:76). Qualitative research is a social inquiry that concentrates on how human beings create meaning based on their experiences and the universe in which they live (Holloway & Galvin 2016:1). The researcher used a qualitative research design to understand, describe, and interpret the registered nurses' experiences managing patients diagnosed with depression in a general medical ward.

The registered nurses were found to have first-hand experience managing patients diagnosed with depression in a general medical ward. A generic qualitative approach

seeks to locate and recognise the situation, activity, perspectives, and opinions of the individuals interacting. The researcher's understanding of the research problem before the beginning of the study was pertinent to the generic qualitative approach. Qualitative research is an inductive approach to understanding the phenomenon under study (Cropley 2019:8) and is established on the foundational view that reality is subjective. Qualitative research emphasises examining how individuals reason their own practical experiences using their intelligence and vocabulary. This makes qualitative research a recognised method for obtaining data and understanding the interaction between human beings.

In this study, the interaction between registered nurses and patients diagnosed with depression in general medical was revealed as the registered nurses unpacked their experiences. A qualitative design assisted in attaining the set objectives as the researcher interacted with registered nurses to acquire an in-depth understanding of their perceptions and experiences of managing patients diagnosed with depression in a general medical ward.

The exploratory research design investigates the whole nature of the phenomenon (Polit & Beck 2021:595). Descriptive research helps researchers observe and describe their findings. Hunter, McCallum and Howes (2018:2) posited that a descriptive study intends to write and explain the experience of interest. In this study, the phenomenon of interest was the registered nurses' experience managing patients diagnosed with depression in a general medical ward.

Holloway and Galvin (2016:2) highlighted that qualitative designs are interrelated to the individualistic character of truth. The foundation of the qualitative research is on the interpretive approach to reality and interpretation of lived experiences of the study participants. The researchers should first familiarise themselves with the natural surroundings of human beings whose experiences are the study phenomenon of interest. Descriptive research aims at accurately portraying the characteristics of a group or situation, attitude, or views of a person towards a particular phenomenon. A qualitative research design follows the interpretive paradigm and is naturalistic because it happens in a natural setting, in this case, a private hospital. Qualitative research heavily emphasises understanding human experience as it is lived through careful collection and analysis of qualitative material that is narrative and subjective.

Opinions of the participants are crucial for a better understanding of the experiences on the topic under study. In this study, the researcher was interested in the registered nurses' experiences managing patients diagnosed with depression in a general medical ward. Gray and Grove (2020:33) posited that qualitative researchers give rise to knowledge about meaning through exploration. Findings are distinct, and the researcher does not intend to generalise the research outcomes to a bigger population. Exploratory, descriptive qualitative research is applied to deal with a problem that needs to be analysed (Gray & Grove 2020:34). A qualitative research design was appropriate for this study as it consolidates various data collection strategies. In-depth face-to-face interviews, field notes, and reflection were the data collection strategies used for the study. Qualitative designs are adjustable and can be modified where needed.

Qualitative research designs tend to be holistic, striving to comprehend the whole; it propels the researcher to become the research instrument and continue the data analysis process. Qualitative methods concentrate on the qualitative characteristics of interpretations of meaning, experience, and apprehension. The human experience is studied from the perspective of the research participants in the environment where the activities occur and not from the view of the researcher (Brink et al 2018:121).

3.4 RESEARCH METHODS

A research method is defined as a process used to construct a research study, to collect and scrutinise data that is appropriate for the research study (Polit & Beck 2021:801). The master philosophical assumption of qualitative research is that reality is constructed by individuals' interaction with the social world. It is assumed that people's experiences produce meaning (Santosh 2021:1).

The participant's perspective takes a leading role and not the researcher's point of view. In qualitative research, methodological assumptions refer to the use of naturalistic methods of inquiry as the phenomenon of interest is explored directly at the place of occurrence. There is no form of manipulation of the phenomenon of interest by the researcher. The experiences of the registered nurses were taken from managing patients diagnosed with depression in a general medical ward, which is a natural setting.

In this study, qualitative research methods were used to understand the meaning registered nurses assign to the experiences of managing patients diagnosed with depression in a general medical ward. Qualitative research methods describe data in words, not in numbers, leading to a better understanding of the participant's constructed meanings. The emphasis was more on the quality and depth of the information provided.

Qualitative research offers an opportunity to focus on finding answers to questions centred on social experience, how it is created, and how it gives meaning to human life. Voices and interpretations of registered nurses are important to understand the phenomenon of interest and subjective interactions are the primary ways to access them.

3.4.1 Population

The population is the number of cases that a researcher is interested in inviting to the study. This is a group of individuals that meet the criteria the researcher is interested in studying (Polit & Beck 2021:52). In this study, the population comprised of all 12 registered nurses permanently employed in the two general medical wards of the selected hospital. The study population was small. Therefore, all registered nurses working permanently in the target general medical wards were invited to participate in the study.

3.4.2 Sampling

The invitation to participate in the study was sent to all 12 registered nurses managing patients diagnosed with depression in the two general medical wards of the study site. Therefore, no sampling was done.

3.4.3 Data collection

Data collection in qualitative research not only refers to the collection of data but also to anticipating ethical issues, gaining permission, developing means for recording information, and responding to issues that arise during fieldwork (Creswell & Poth 2018:147). In the case of this study, the COVID-19 pandemic delayed data collection, and additional measures needed to be taken to ensure participant safety. Ten participants consented to take part in the study. In-depth, face-to-face interviews were used to collect the data (Hofstee 2018:115). Interviewing is considered a social interaction based on a

conversation between the researcher and the participants (Creswell & Poth 2018:163). Due to the in-depth nature of the interviews in a qualitative research study, the researcher could obtain new knowledge and insights into the study topic.

3.4.3.1 Advantages and disadvantages of the interviews as a data collecting instrument

There are advantages as well as disadvantages of using interviews for data collection. Interviews are practical in taking in-depth conversations compared to other methods of data collection. Researchers obtain more information through the use of interpersonal skills that encourages participants' cooperation. Researchers can read both verbal and nonverbal information that may assist in data analysis (Gray & Grove 2020:405).

In-depth interviews help researchers get more responses from the participants than using questionnaires. In this study, **the advantages** were that the researcher was able to gain an in-depth meaning of registered nurses' experiences in managing patients diagnosed with depression in a general medical ward. The researcher was able to obtain more clarity through follow-up questions. The researchers were able to sustain good interpersonal relationships with participants that resulted in transparency in this study; the researcher was able to build trust and obtain cooperation from the participants. In this study, the disadvantages were that the interviews can be highly time-consuming. Some of the participants brought their concerns about being nurses during the COVID-19 pandemic. Interviews bring a high risk of personal bias. The research could be judgemental or stereotyped.

3.4.3.2 Data collection process

Permission was obtained from the Organisation's Research Operations Committee to use the hospital as the study site for data collection (Annexure C). A participant information sheet with a consent form was sent to all registered nurses in a general medical ward (Annexure D). Registered nurses who gave consent to participate in the study were given time to ask questions before signing the study consent form. The registered nurses were then regarded as study participants. The registered nurses were permanently employed in the hospital under study, managing patients diagnosed with depression in two of the general medical wards.

Interviews occurred outside of official working hours, for example, before or after shifts, so as not to compromise official working hours or a period that would be convenient for each participant. Because South Africa was still under eased regulations under level one of lockdown, sanitising the chairs and the table after each session was enough as COVID-2019 precautions. The researcher and the participants would be screened at the hospital entrance as a routine for everyone who enters the hospital premises. A surgical face mask, visor, and a hand sanitiser were provided for the researcher and each participant at the entrance of the meeting room.

The researcher planned the seating arrangement strictly considering the COVID-19 rules. The face-to-face interviews demanded that the researcher, as the interviewer and participant, sit opposite each other on the square table. The interview sessions were one hour apart to prevent participants from interrupting the interview and allow time to sanitise the chairs and table after each participant. The time space was also made to prevent the participants from bumping into each other and bridge the confidentiality of the participants.

The interviews took place in the general medical ward's meeting room. A sign "Please do not disturb, meeting on progress" was placed at the outer part of the door. Before the interview, reflexivity and bracketing were applied where the researcher put aside her preconceived ideas so that every participant's viewpoint could be considered fully and authentically (Creswell & Poth 2018:321). An interview protocol was developed to direct the activities during the interview and form the basis of the fieldnotes or records during the interview (Creswell & Poth 2018:325). The researcher did a pilot test of the protocol with two agency registered nurses who were not permanently employed by the hospital. The interview recordings were sent to the supervisor, who checked the interviewing techniques, listed for potential biases or leading questions, and provided feedback. The interview guide and questions remained unchanged (Annexures E and F).

The researcher explained the process of the interview session up to the closing. Unfortunately, the COVID-19 rules deprived the interviewer and interviewees of the benefits of facial expression due to the personal protective equipment used. The interviewer first built a good rapport with each participant before commencing the interview with questions such as 'Please introduce yourself?' and the researcher would

introduce herself to the participants (Creswell & Poth 2018:155). Interviews were conducted in English only, which helped the participants communicate freely and show interest in the sessions. After building rapport, the researcher would ask a grand tour open-ended question: ‘How is it for you to manage patients diagnosed with depression in a general medical ward?’. This was followed by facilitative communication techniques such as probing, clarifying, summarising, and reflecting.

Permission to audiotape the interviews was asked from each participant who gave consent to audiotaping sessions. All interviews were audio-recorded using a high-quality microphone audio recorder and transcribed verbatim by the researcher, with field notes taken for backup in case of the recording equipment failing. One participant at a session would be interviewed for approximately forty-five minutes, which also ensured prolonged engagement. The researcher would clarify the questions to the registered nurses participating in the study, obtain their viewpoints, and judge if the data reached saturation and no new information could be obtained.

The registered nurses started repeating the same information, meaning data saturation was reached (Polit & Beck 2021:55). During the interviews, there were no participants that displayed emotional distress, although they shared their experiences with passion. Observation and field notes were taken during and after the interviews that reflected notes about the researchers’ experiences during the interviews, hunches, and learning, as well as insights and tentative interpretations (Creswell & Poth 2018:169).

Field notes are one of the forms of record-keeping in the qualitative study, meaning only factual information is documented (Phillippi & Lauderdale 2018:381). Field notes provide an assessment of the research study findings by interpreting the data across qualitative studies. Reflective notes in the qualitative research study propel the researcher to take time and reflect on their performance both as an interviewer and a participant (Philippi & Lauderdale 2017:384). Reflexivity means looking back and deep into oneself and checking personal beliefs that could influence the gathering of information and interpretation (Polit & Beck 2021:156). In this study, debriefing interviews with the supervisor took place before and during data collection and data analysis.

3.4.4 Data management

Qualitative research can produce great volumes of data that need to be appropriately curated; therefore, creating effective, long-term and protected file storage was necessary. Data were collected for the study only. Creswell and Poth (2018:185) argue that researchers must sort out their data into documents, create files, and give them names at the onset of the data analysis action. In this study, the researcher could keep track of interrelatedness between numerous portions of data from different participants by taking notes and recording audio. The file naming system helped the researcher to easily find the material for analysis either manually or information processing system.

3.4.4.1 Organising data files

One of the ethical principles in research studies is the confidentiality and anonymity of the participants. Organising data helps the researcher avoid losing any data and reach accurate findings and conclusions. In this study, the researcher organised and arranged files. The researcher avoided struggling to retrieve the data by arranging them properly during data analysis. The researcher started organising the data files before embarking on interview sessions with each participant.

The researcher created folders with pseudonyms to avoid using the participants' names. The folders were structured alphabetically based on the participants' aliases. The researcher labelled all audio and written transcription documents to prevent confusing the data collected. After five years, the data on paper will be shredded, and the researcher will delete the data stored in the computer from both the recycle bin and the documents.

3.4.5 Data analysis

Transcription is essential and is the first step in data analysis. The researcher used a fine transcription approach where all transcriptions were transcribed verbatim (Moore & Llompart 2017:410-411). The researcher started the thematic data analysis process as described by Creswell and Poth (2018:185) by reading through the scripts that were transcribed and engaged with the data. The researcher dismantled the raw data from the transcripts to group the information. Similar information was grouped and coded together. Different colour highlighters were used to distinguish the codes. The researcher searched

for themes that emanated from the data collection. The data coding helped the research to be immersed with the data collected. The researcher perused and read through the data codes and expressions of the participants repeatedly and grouped them into categories. Similarities and differences between the data codes were identified.

Data were then analysed using a thematic analysis process by reading through all data categories to determine the connection of the categories to the study. Data analysis in qualitative research requires formulating, codifying, classifying, manipulating, and summarising data into themes by coding and representing the data in figures, tables, or discussion (Creswell & Poth 2018:183). Data analysis aims to assemble the data into significant and separate interpretations or theories. Qualitative researchers use much of their time reviewing and interpreting the data. The researcher becomes entirely absorbed by the data (Polit & Beck 2021:180).

The researcher listened to the audio taped during the interviews and noted the interactivities or thoughts that came to mind. The researcher then read the verbatim transcripts of the participants to obtain a sense of the whole. At this phase, the researcher has already familiarised herself with the data and had an idea of what is in the data. The researcher started the initial coding of the data. The research looked at the exciting parts of the registered nurses' experience in managing patients diagnosed with depression in a general medical ward. The researcher could obtain circumstances in the responses of the participants.

The researcher searched for themes that emanated from the data collected. The interconnections between data provided by different participants helped the researcher assign explicit measures and statements to individual participants. The researcher differentiated between the concepts that applied to all registered nurses and those that applied only to specific individuals. Pseudonyms were used instead of real names as the ethical obligation to confidentiality.

In this study, the data analysis was inductive. The process of data analysis assisted the researcher in being familiar with the data until the results were obtained. This study's findings were unique to the study. The researcher made reflections on being able to comprehend the occurrences. The outcome of this research study was not the generalisation of the results but a deeper understanding of the experiences of registered

nurses in managing patients diagnosed with depression in a general medical ward. The supervisor assisted as co-coder.

3.5 ETHICAL CONSIDERATIONS

It is vital for every research study to apply appropriate ethical principles to protect participants (Arifin 2018:30). Researchers need to consider what ethical issues might be found during the research and plan how to address these issues (Creswell & Poth 2018:63). To embed ethical study practices in this study, the researcher considered all critical ethical problems during the process of planning, designing, and executing the study. As this study followed a qualitative design that used in-depth face-to-face interviews, ethical considerations were adhered to throughout the study. In this vein, the researcher considered the Belmont Reports' primary ethical principles (Czubaruk 2019:2).

3.5.1 Principle of beneficence

Polit and Beck (2021:121) stated that the principle of beneficence propels the researchers to conduct the study with minimum harm and maximum benefit to the participants. In this study, the participants were assured that it was not meant to harm them but intended to benefit them. The participants would benefit through sharing their experiences whereby others could better understand, the participants may gather greater personal insight and they may have a platform to voice their concerns.

3.5.2 Protecting participants from injury

This principle forces researchers to prevent suffering or injury to participants in all research studies. Research participants should not be exposed to any injury during the study (Polit & Beck 2021:121). In this study, risks to the participants were minimised. The interviews were conducted with strict adherence to COVID-19 regulations. The emotional and psychological harm was the only anticipation. Participants could experience emotional discomfort in expressing their experience in managing patients with depression. Should such emotional or psychological disturbances have occurred, the affected person would be referred to an organisational health employee free of charge. The organisational health employee would then provide the participants with the initial

level of support and schedule counselling sessions. This intervention was not needed in this study.

3.5.3 Obtaining informed consent

Participant informed consent is a critical element of ethical scholarship. In this light, all participants were transparently informed of their rights, research objectives, and all pertinent information related to the inquiry. The researcher assured the participant's data obtained from the interviews would not be used to compromise them. Participants were free to choose to join the study with the liberty to withdraw from the study at any time and without any negative consequences.

3.5.4 Right to privacy

Privacy is the right of the individual to determine the time, place, extent, and general circumstances under which information will be collected, shared, or withheld from others (Brink et al 2018:5). The interviews were conducted in the medical ward conference room, the place of choice for all participants. The room is always locked, and the unit manager keeps the keys to minimise unwanted entry. This prevented uninvited people from disturbing the sessions. The conference room was used to allow a two-meter space between the interviewer, who was the researcher, and the participants during one-on-one in-depth interviews.

3.6.5 Right to confidentiality and anonymity

Confidentiality and anonymity are the guarantees made by the researcher to the participant that no participant's details will be made known to the public. The data were kept private. The study findings were presented in a way that did not get associated with the participant (Hofstee 2018:135). The researcher ensured confidentiality and anonymity by reporting the findings without divulging participants' identities. Participant codes were used instead of participants' real names, for example, P1.

3.5.6 Right to fair treatment

The researcher should be someone of the highest integrity who gives the participants the same chances of participating. The participants should always be fairly treated (Creswell & Poth 2018:150). No favouritism was used for or against a participant. The participants were treated equally. The researcher avoided applying prejudice or bias against participants. There was no injustice of any kind permitted during the study (Polit & Beck 2021:121). Registered nurses in a general medical ward were given equal chances to participate voluntarily in the study. There was no exploitation nor exclusion of the registered nurses in a general medical ward from the study.

3.5.7 Scientific integrity of the research

Researchers should strive to maintain objectivity at all times, as it proves the faithfulness of facts in the conduct of scientific research. Research findings should be presented honestly without manipulation of information received from participants (Van Dongen & Sikorski 2021:3). The researcher complied with scientific integrity by acknowledging sources of information to prevent introducing ideas of other writers as her own (Polit & Beck 2021:180). Falsification of the study was avoided by presenting the research findings without manipulating, changing, omitting data, or distorting results to the ensure honesty. Awareness of fabrication was taken into consideration. The results of this study reflect what was gathered during the research process.

3.6 SUMMARY

This chapter outlined the research paradigm, research design, and methods; the study population, data collection, data analysis, ethical considerations, and scientific integrity of the research were also discussed. The research findings from the data collection and analysis will be analysed in detail in Chapter 4.

CHAPTER 4

DESCRIPTION OF THE RESEARCH FINDINGS

4.1 INTRODUCTION

The purpose of the study was to seek an in-depth understanding of the experiences of registered nurses in the management of patients diagnosed with depression in a general medical ward. The previous chapter discussed the research design and methods. This chapter presents the research findings of the data derived from transcribed interviews and field notes with participants.

4.2 DESCRIPTION OF THE DEMOGRAPHIC DATA OF PARTICIPANTS

The study's target population was all registered nurses who cared for patients with depression in two general medical wards in a private hospital. Ten participants consented to take part in the study. Table 4.1 presents a summary of the demographic profile of the participants.

Table 4.1 Demographic profile of participants

Participant numbers	Age (years)	Gender	Registered nurse experience (in years)
1	51	Female	8 years
2	49	Female	10years
3	33	Female	6 years
4	35	Female	7 years
5	28	Female	4 years
6	43	Female	13 years
7	38	Female	10 years
8	29	Female	3 years
9	34	Female	9 years
10	37	Female	12 years

All ten participants were black females, fluent in English. The ages of the participants ranged from 28 to 51 years with a mean age of 22 years, with three to seven years of work experience. The general medical ward is covered by female registered nurses only, as nursing is internationally, and in South Africa, a mostly female-dominated profession (Clayton-Hathway, Humbert, Griffiths, McIlroy & Schutz 2020:11). The participants were

qualified as registered nurses with a diploma in general nursing science and registered with the South African Nursing Council, the licensing body. Most registered nurses received their training in the hospital X's Education Department and completed their practical hours in the hospital where the study was conducted.

4.3 RESEARCH OBJECTIVES

The objectives of the study were twofold. The research was intended to:

- Explore and describe registered nurses' experiences in managing patients diagnosed with depression in a general medical ward.
- Identify potential opportunities for improving the nursing management of patients diagnosed with depression in a general medical ward.

4.4 RESEARCH FINDINGS

The study findings produced three main themes with categories and related codes. The central storyline indicated that detecting depression on admission or during hospital stay in a general medical ward is experienced as problematic for registered nurses. Specific aspects increase difficulties. Nurses had a lack of psychiatric training or experience, a lack of staff lead to poor assessment of patients, and patient acuity tools limited the number of staff available to care for patients. Nurses experienced hospital management as unsupportive. The COVID-19 pandemic added additional complexities of care faced by nurses and increased their vulnerability. The nurse-patient relationship was compromised due to social distancing, further staff shortages, patient mortality, death anxiety, and shortage of protective clothing. Nurses lived in fear of contracting the virus, as some patients were admitted with COVID-19 as well. In turn, patients equally had death concerns and suffered an additional burden due to social restrictions brought about by COVID-19 regulations.

The participants verbalised that most of the patients are admitted without a known history of depression; they are admitted for physical illnesses. With this knowledge, several recommendations are put forth. Table 4.2 provides an overview of themes, categories, and codes. Each will be discussed with verbatim quotes in *italics* as evidence.

Table 4.2 Summary of themes, categories, and codes

Themes	Categories	Codes
1 Detecting depression on admission or during hospital stay is a problematic experience	1.1 Challenges registered nurses face	• Registered nurses in a general medical ward often lack psychiatric training • Shortage of staff in a general medical ward negatively affects the treatment of patients diagnosed with depression • Staffing acuity tools limit the number of nurses on duty • Lack of support from hospital management
2 The COVID-19 disease pandemic and management of patients diagnosed with depression in a general medical ward	2.1 The additional complexity of care faced by nurses increased their vulnerability	• Limitations in the nurse-patient relationship due to social distancing. • Nurse shortage during the COVID-19 pandemic • Patient mortality and death anxiety • Shortage of personal protective clothing at the beginning of COVID-19 • Fear of being infected with COVID-19 as some patients with depression were also admitted with COVID-19
	2.2 Patient concerns reported by nurses	• Fear of dying • No visitors were allowed for COVID-19 patients, creating additional feelings of isolation
3 Recommendations	3.1 Registered nurses need the support of hospital management	• Ensure the safety of a patient diagnosed with depression, fellow patients, nurses, and all members of the multidisciplinary team • The hospital management to establish specific risk management strategies for the general medical ward

4.4.1 Theme 1: Detecting depression on admission or during hospital stay is a problematic experience

A general medical ward is a unit allocated to patients with various physical diseases admitted for conservative treatment that do not require surgical interventions (*Collins English Dictionary* 2001, sv "context"). Patients are often admitted to a general ward with '*other'* conditions such as diabetes mellitus, neurological conditions, rheumatological conditions, respiratory and cardiological conditions, renal failure, haematological disorders, or cancer. Patients often do not admit or are unaware that they are depressed or taking treatment for depression.

> *It is difficult to detect that the patient has depression while admitted to a general medical ward. [P4]*

> *According to me, it is hard because normally in the general medical ward, patients with depression come with another illness only to find out later that patient is having. [P7]*

> *Sometimes you will find that you have those patients who came in with such comorbidities, but you treat them as normal patients only to find that things that they will do like maybe harming themselves. [P2]*

> *Some patients diagnosed with depression in a general medical ward will say "I am not depressed" while they are depressed. [P3]*

> *A patient will come due to uncontrolled blood pressure and not mention a history of depression on admission, after some time a patient will display changes in the behaviour when I assess deeper and do other investigations, the patient will reveal that they are taking medication for depression at home. [P6]*

Depression is common in a general medical ward but remains problematic when not identified, detected, or addressed (Hantrakul et al 2020:22). Munro and Milne (2020:19) mentioned that detecting and diagnosing depression on admission and during a hospital stay of a patient in a general ward is often missed because other physical illnesses present with much the same symptoms as depression. Physical conditions such as

hyperthyroidism also present with mood swings, poor attention span, and tiredness, which add a reference.

4.4.1.1 Category 1.1: Challenges that nurses face

The challenges stemmed from several issues, such as nurses lacking psychiatric training, a shortage of nursing staff, staffing acuity tools that limit the number of staff available at a given time, and the perceived lack of support from hospital management.

4.4.1.1.1 Registered nurses in a general medical ward often lack psychiatric training

Registered nurses were mainly qualified in general nursing science in a general medical ward and lacked specific training, such as psychiatric training. When patients present with '*strange*' behaviour, the untrained nurse may not be able to explain the behaviour. The work environment becomes stressful if registered nurses lack the knowledge and skills to manage patients that are diagnosed with depression in a general medical ward. Most of the participants highlighted the need for psychiatric training, in the form of a specific course or in-service training.

> *As a general nurse, I find it difficult to manage patients with depression in a general medical ward because I am not psychiatric trained and I treat them as normal medical patient patients only to find them with strange behaviour such as when a patient cuts himself with a knife and a fork from her lunch food tray when we dug and followed up the history, we found out that the patient was a psychiatric patient, but we nursed the patient like any patient with a general medical condition. I think if we can be trained it might be easier for us to manage such patients. [P2]*

> *Yes, I must be sharpened. So, I think the management should organise a program whereby nurses are equipped in the management of patients with depression in a general medical ward. [P5]*

> *A course in managing patients with depression and confusion in a general medical ward is needed, in this medical ward, especially for the registered nurses. [P8]*

Despite ongoing efforts to train nurses in the identification of depression, it remains poorly diagnosed and treated globally and in South Africa (Kraus et al 2019:1). Support is

essential for patients diagnosed with depression. However, some healthcare professionals do not have the ability to provide various types of support to patients diagnosed with depression. Borglin et al (2019:5) advocated that these general nurses be trained to support patients with depression and to assess, implement, monitor, and evaluate the nursing care of patients.

4.4.1.1.2 Shortage of staff in a general medical ward negatively affects the treatment of patients diagnosed with depression

The shortage of nurses in a general medical ward could be associated with the poor quality of nursing care provided. The participants stated that the staff shortage limits them from providing care in the form of an integrated nursing approach. Patients diagnosed with depression in a general medical ward are placed amongst patients with physical illnesses, and a shortage of staff prevents registered nurses from giving these patients the special attention they deserve. The participants conveyed that managing patients with depression with a one-nurse per patient allocation ratio can help to create greater availability of a nurse at the bedside. Patients diagnosed with depression could have more opportunities to have conversations with nursing staff and be assisted according to their needs. The shortage of nurses in a medical ward puts the patient's life at risk, nurses become dissatisfied.

> *In nursing comprehensive approach is demanded, but how one will be able to give an integrated approach if there is a shortage of staff? Sometimes you need to address other patients while a depressed patient needs your attention. There is often not enough attention given to the patients diagnosed with depression by the registered nurses because there is mostly one registered nurse in a shift and there are other patients that get sicker and resuscitated. [P3]*

> *Allowing us extra staff to nurse patients diagnosed with depression in a general medical ward would save trouble in the unit. Patients diagnosed with depression would be professionally managed in one-on-one nursing care. [P9]*

> *So, it's difficult, and at the same time, when we are short-staffed, we don't even have time to spend with one patient and then try to get what is happening. [P4]*

Nurses are essential for providing compassionate care in all healthcare systems. Quality of care is achieved by assigning an adequate number of nurses with the necessary skills and abilities (Muabbar & Alsharqi 2021:35). The participants stated that rendering an integrated approach is made difficult by the shortage of nurses in a general medical ward. The patients diagnosed with depression need special attention from nurses, but the general medical ward is mostly covered by one registered nurse on a shift. Haddad, Annamaraju and Toney-Butler (2020:2) posited that a shortage of nurses' results in errors and an increased death rate in hospitals. Suhaimi, Mulud, and Sharoni (2021:78) mentioned that the scarcity of nurses is a matter of great concern, as it makes rendering quality care a challenge in the health system. Zhang, Zhang, Xu and Yun (2021:2216) argued that the shortage of nurses is a global challenge due to global competition, the elderly population, and the nursing delivery demands in the healthcare sector.

4.4.1.1.3 Patient acuity tools limit the number of nurses on duty

Acuity tools support equitable patient assignments through making fair and equitable staffing decisions (Eastman & Kernan 2022). In addition to staff shortage, patient acuity tools were also problematic when providing care to patients diagnosed with depression in a general medical ward. Participants acknowledged the value of acuity tools but were unhappy with some aspects. They felt that these tools hampered the one-on-one care needed by patients diagnosed with depression.

> *Acuity tools compromise the nursing care rendered to a patient. Acuities help us to work but personally, I feel like it is tough to manage these patients with depression. Acuity tools compromise the nursing care rendered to a patient. Acuity tools prevent the shift leaders to assign patients with depression to one-on-one nursing care even when necessary. [P8]*

> *It is difficult to connect several registered nurses to several patients in a private sector without depression as a diagnosis or comorbidity. Patients diagnosed with depression aggravate the off-balance between patients' acuity tools and available nursing staff. I do wish there were no limitations in assigning nurses in a general medical ward. The acuity tools that are currently used need to be revised, so that we can get a suitable number of registered in a general medical ward and reduce the patients' complaints. [P9]*

To be honest sister it would have been easy if we run the general medical ward with a suitable number of nursing staff, all categories. The management always tells us about the adherence to patient acuity tool and it limits the number of staff provided to the unit. [P1]

A patient acuity tool is a recording tool that communicates the management decisions to the staffing levels needed to cover the nursing unit and is crucial, as it influences the quality of patient care and safety (Al-Dweik & Ahmad 2019:34). Patient acuity tools are necessary to attain equal allocation of workload to achieve empirical outcomes, best patient experience, and most cost-effective nursing care. Different healthcare groups design patient acuity tools differently, but for the same goal. Ageiz & El-magged (2020:453) explained that the patient acuity tool helps to initiate nurses' allocation of patients. The patient's clinical condition and the challenges in implementing nursing activities are considered by the acuity tool. The registered nurses are expected to do the patient level of care grading, then acuity tool will suggest the number of nurses necessary for the twenty-four-hour shift planning for patients in a general medical ward. The patient acuity tool should always match nursing shift assignments to produce empirical outcomes. An increase in the number of registered nurses in nursing units results in better patient experience, quality care, high levels of patient satisfaction, decreased mortality rates, decreased patient length of stay in the hospital, and less nursing errors in nursing care (Griffiths, Saville, Ball, Jones, Pattison & Monks 2020:2).

4.4.1.1.4 Lack of support from hospital management

The participants mentioned an increase in responsibilities and expectations from them, yet they perceived a lack of support from management. Registered nurses were expected to be shift leaders and bedside nurses. The participants verbalised that there is less support from the hospital management in the management of patients diagnosed with depression in a general medical ward. The registered nurses felt that the hospital management was only interested in their omissions and using their omissions against them. The registered nurses feared losing their jobs the moment they are told to write an incident report.

According to the management as a registered nurse and a shift leader you were supposed to have noticed that the patient has depression, you were supposed to

have seen the signs and prevented the patient diagnosed with depression from committing suicide. [P2]

The patient that was admitted with a drug overdose took and broke a glass by hitting it on a bedside locker and cutting both of her wrists and arms with that glass, when I, as the shift leader notified the night manager at the beginning of the night shift, All the nurses were blamed of not taking good care of the patients. We were interrogated, and threatened that we would lose our jobs. [P10]

During my shift, a patient jumped out of the window and died. I was interrogated, as a shift leader where were you when the patient jumped through the window? Have you seen the patient jumping through the window? Meaning that you were not around. [P5]

One patient with COVID-19 and depression, during the second wave of COVID-19 surge, the patient dropped himself from the third floor of the hospital to the street road. A pedestrian who was walking behind the hospital noticed and shouted and called the police, the patient was already dead. The management came to interrogate the staff, being the shift leader, I could not go home, because I had to write an incident report and statements and explain what happened in the management offices. [P8]

Registered nurses are responsible for communicating the treatment plan to the patient and other members of the multidisciplinary team in a general medical ward (Afriyie 2020:450). Patients diagnosed with depression also have physical illnesses. The combination of physical illnesses and depression takes time from the already overloaded registered nurses. Registered nurses still have the responsibility to collaborate with other members of the multidisciplinary team for the best patient outcomes.

Currently, more than before, registered nurses require psychological support to maintain mental stability and to minimise depreciation of health status during the COVID-19 pandemic; this challenge requires a full workforce. Psychological support should be provided by all healthcare organisations (Catania, Zanini, Hayter, Timmins, Dasso, Ottonello, Aleo, Sasso & Bagnaso 2020:408). Sahebi, Nejati-Zarnaqi, Moayedi, Yousefi, Torres and Golitaleb (2021:1) argued that the hospital management team is expected to care for the mental status of all healthcare personnel, especially nurses, as they spend a

great amount of time with COVID-19 infected patients and without diligent nurses, healthcare systems can collapse.

4.4.2 Theme 2: The COVID-19 pandemic and management of patients diagnosed with depression in a general medical ward

The previous theme demonstrated the difficulties inherent in managing patients diagnosed with depression in a general ward. Data were collected during the third wave of the pandemic, and nurses related how the pandemic and COVID-19 added additional pressure, dynamics, and burden on their nursing care and related patient concerns.

> *Those patients came with COVID-19 made things more serious; they came in depressed, confused. This was two to three problems altogether. Depression is a twin to COVID-19. [P6]*

> *In the general medical ward, it was worse; you see things. While you still helping a patient with COVID-19 another one deteriorates, so it caused depression in patients. Most of the patients during the COVID-19 peak acquired depression in the ward when their neighbours deteriorated and even died. [P5]*

> *During the COVID-19 pandemic, depression also took its toll on the patients in a general medical ward. Some patients became arrogant and aggressive, forced to go home, and were violent towards the healthcare personnel. [P9]*

Thaweerat, Pongpirul, and Prasithsirikul (2021:2) posited that patients with COVID-19 admitted to hospital were found with a high frequency of anxiety and depression, especially at the peak of each wave. in fact, mental disorders such as depression and anxiety were found regularly in patients admitted with COVID-19 in healthcare services (Dai, Wang, Jiang, Li, Wang, Wu, Jia, Liu, An & Cheng 2020:8). Shader (2020:1) raised concerns about the prevention of global COVID-19 depression, as COVID-19 can bring about a depression epidemic in an already overwhelmed health system.

4.4.2.1 Category 2.1: The additional complexity of care expected from nurses increased vulnerability

The COVID-19 pandemic appeared to have a bidirectional impact on patients admitted to a general ward and added to the complexity of managing these patients, increasing nurses' vulnerability.

4.4.2.1.1 Limitations in the nurse-patient relationship due to social distancing

Registered nurses verbalised that they were afraid and felt underprepared to provide nursing care to patients with COVID-19. Because COVID-19 care was so demanding and the number of patients increased, nurses were advised not to spend too much time with each patient. Despite these challenges, the nurses seemed to have made a wilful decision to provide the best care.

> *At first, we nurses, I think we were supposed to be prepared. We come to this COVID-19 unpreparedness knowing what exactly we are facing. [P5]*

> *We were told not to take a long time at the patient's bedside if you are admitting a patient do not take long just take 15 minutes to avoid standing a long time next to a very sick patient. [P6]*

> *I was also scared to nurse the COVID-19 patients at first but seeing that patients have no one else they have in this COVID-19 ward, seeing how desperate and some have lost hope, I picked myself up and I was like I am going to nurse them with full compassion, and I am doing that. [P1]*

Registered nurses and patients diagnosed with depression in a general medical ward both benefit from a therapeutic nurse-patient relationship. The nurse-patient relationship is a leading factor that plays a crucial role in positive patient feedback on nursing care rendered at the bedside and is interrelated with the best patient experience and empirical outcomes (Cilluffo, Bassola, Pucciarelli, Vellone & Lusignani 2021:1718). Only nurses with strong determination could maintain effective communication and cooperation with patients while empathising with the patient at the bedside (AbuSharour, Bani Suleiman, Subih, El-hneti, Al-Hussami, Al-Dameery & Ali-Omari 2021:1). Chau, Lo, Saran, Leung,

Lam and Thompson (2021:3) highlighted that during COVID-19 nurses needed to adapt on multiple levels.

The researcher observed the members of the multidisciplinary team working under social distancing measures and jotted this down in the observation notes. Some would talk to the patients at the door, avoiding coming closer to the patient. Patients still needed physical examination and assessment by registered nurses, even during the pandemic. Some patients advised nurses not to go near them because they would die.

4.4.2.1.2 Nurse shortage during the COVID-19 pandemic

The shortage of nurses was also a concern in the previous theme. With the COVID-19 pandemic, this aspect was exasperated and severely pressured the health sector, and especially nurses, to meet the demands. Nursing shortages lead to poor patient outcomes and dissatisfied staff that considered leaving the profession.

> *As a registered nurse, I am seriously bothered by a shortage of staff, I must run a shift, all the nurses report to me, and when they report, I am expected to act promptly but most of the time I get overwhelmed. There is an overload for the registered nurses, especially during the COVID-19 surge from June to July 2021, the staffing levels dropped day by day. The staff got tired and took rest days instead of doing extra shifts. The process of putting on and taking off personal protective equipment when attending to patients made nursing care difficult especially when dealing with patients with depression as a comorbidity to a physical illness. [P1]*

> *With the staff shortage, you tend to forget about a patient, and you take time to check how the patient is doing cause your hands are full full-full. [P2]*

> *So, it's difficult, and at the same time, when we are short-staffed, we don't even have time to spend with one patient and then try to get what is happening. [P4]*

> *Cause now what I see now, because of this difficulty, people are resigning. People are leaving; we don't know, they are leaving, a lot, a lot from last year nurses are resigning'. [P5]*

I don't mind working with COVID-19 patients with depression as comorbidity if I have enough staff as a shift leader. You are a shift leader and a bedside nurse due to a shortage of staff. [P8]

Sims, Leamy, Levenson, Brearley, Boss and Harris (2020:1) stated that nurses are essential for providing compassionate care in all healthcare systems. Quality of care is achieved by assigning an adequate number of nurses with the necessary skills and abilities (Muabbar & Alsharqi 2021:35). Haddad et al (2020:2) found that a shortage of nurses' results in errors and an increased mortality rate in hospitals. The COVID-19 pandemic intensified the scarcity of nurses (Kim & Kim 2021:3). Work-related factors, including lack of staff, working long hours, increased workload, and insufficient rest time, were other main issues that led to fatigue and psychological drain (Dall'Ora, Ball, Reinius & Griffiths 2020:2).

4.4.2.1.3 Patient mortality and death anxiety

The registered nurses in a general medical ward experienced that COVID-19 was more dangerous than any other condition because it killed young and old people. Registered nurses expressed the devastating state under which they were working, voicing a desperate plea for support and counselling. Different participants verbalised that it was strange for them to see young(er) patients dying in large numbers daily. One of the participants stated that they are used to patients recovering and not dying day by day.

It was so devastating to see especially young people dying every day. You must lay the bodies every day. It was so difficult for us as nurses. [P2]

But I think nurses needed psychological counselling during those early times because it was too much, it was too much. Every day is laying a corpse, every day laying a corpse, yet we are not used to those things. We are used to healing. [P4]

So COVID-19 people know that COVID-19 is more dangerous than any other condition because it kills you; you can die in a short space of time. [P5]

Aydın and Fidan (2021:12) stated that fear and anxiety caused by thinking of dying have escalated during the pandemic, and that nurses dealing with death anxiety may experience adverse reactions when caring for dying patients. Death anxiety has been

implicated in the development of many mental disorders. Mosheva, Gross, Hertz-Palmor, Hasson-Ohayon, Kaplan, Cleper, Kreiss, Gothelf & Pessachi (2020:474) explained that during the COVID-19 pandemic, the anxiety about the death of nurses and patients was often caused by the death of other patients of the same or younger age to them. During the COVID-19 pandemic and due to restrictions on human contact, patients separated from their family members, were left to die alone. Healthcare personnel were left with no guidance, and decision making was not based on logic, which created more fear and anxiety about death (Yardley & Rolph 2020:1). The mortality rate of COVID-19 was very high and scary due to the strange nature of the disease and the lack of scientific knowledge, and the appearance of clinical manifestations increased anxiety among both nurses and patients (Khademi, Moayedi, Golitaleb & Karbalaie 2020:347).

4.4.2.1.4 Shortage of personnel protective clothing at the beginning of COVID-19

Personnel protective equipment (PPE) was the only means to protect healthcare workers and patients at the start of the pandemic, yet it was scarce and expensive. This caused tension between nurses and management. Some nurses reverted to buying their supplies of PPE.

> *We blamed management for saying they are not giving us personnel protective equipment; it was a mess. We were fighting management like nobody's business, you will be told to work with just the surgical mask on a patient with COVID-19, so that had a serious impact on the nurses. [P2]*

> *I understand that sometimes management sounds to be less supportive or understanding of the situation but denying us personnel protective equipment during the pandemic was the biggest challenge for us as nurses who have contact with COVID-19 patients. We ended up purchasing or owning scrubs as the staff, we did that because we care about our patients, our health, and our families as well. [P8]*

> *Nursing COVID-19 as a nurse I decided to face the challenges of my career, but I was not happy to find that there is a shortage of personal protective equipment, I got discouraged at first, we were told to keep a surgical mask for seven days. The scrubs for attending to a patient were issued at first, later we were told to purchase them ourselves we did because we were concerned about our health. [P9]*

This finding corresponds with other research where it was stated that wearing personal protective equipment created delays in responding to urgent patient demands (Morley, Grady, McCarthy & Ulrich 2020:35). It limited the speed with which nurses rescue patients even during cardiopulmonary resuscitation. The national stock of PPE was low, which hampered health system efforts (Bhattacharya, Hossain & Singh 2020:223). Burki (2020:786) argued that the shortage of personal protective equipment among healthcare workers led to an emotional burden and increased fear of death. The shortage of PPE increased nurses' fear and anxiety, potentially negatively impacting their mental health (Serrano, Hassamal, Hassamal, Dong & Neeki 2021:28).

4.4.2.1.5 Fear of being infected with COVID-19 as some patients with depression were admitted with COVID-19

Registered nurses in a general medical ward suffered an increased workload during all COVID-19 pandemic waves, increasing the chances of being infected by COVID-19. They felt the increased burden of patients diagnosed with depression due to the virus and pandemic. The high number of very sick patients who needed the attention of registered nurses, along with measures such as social distancing, wearing of protective personnel clothing, and handwashing, added to the workload burden.

Patients admitted with COVID-19 raised concerns from registered nurses, as there are already many nurses who have succumbed to the virus during each wave.

> *We come to this COVID-19 unprepared, not knowing exactly what we are facing. I think there were lots of things I was supposed to do but I did not do to help the patients because of a lack of knowledge and fear for my life. [P5]*

> *This patient with COVID-19 and depression is what I saw, I am supposed to spend time sitting close to my patient but because of fear of being infected and infecting my family, I was forced to spend little time at the bedside. [P3]*

> *I can imagine. We shall still come to the issue of COVID-19 because I believe the pandemic has caused a lot of depression on its own to the nurses, I particularly feared being infected by COVID-19 especially during the first wave because we still did not know how to approach. [P7]*

Registered nurses who manage patients diagnosed with depression in a general medical ward were likely to be afraid of being infected with contagious COVID-19 and transmitting the disease to their families, and fear may cause mental disorders (Wang, Liu, Hu, Zhang, Du, Huang & Yue 2020:1493). The registered nurses had fears emanating from a lack of information about the disease and its nature, and a lack of protective personnel equipment at the beginning of the COVID-19 pandemic. The conditions of patients that would rapidly deteriorate also caused fears for health workers. The virus also spread at a very fast rate in the two years of 2020 and 2021.

Patient outcomes are affected by registered nurses, patient ratio, and nursing competence. The surge in COVID-19 has hurt patient care due to an increase in the demand for registered nurses, clearly creating a gap in nursing care. Every healthcare facility suffered a shortage of healthcare personnel during the pandemic and the quality-of-care was affected (Von Vogelsang, Goransson, Falk & Nymark 2021:2345). Salina and Leena (2021:1) emphasised that healthcare professionals had an overwhelming experience during the COVID-19 pandemic. COVID-19 is contagious and healthcare professionals fear infection by patients.

Patient-centred health and care are essential in providing patient care, but this challenging disease makes it difficult for registered nurses to be frequently available at the patient's bedside. Erdem and Lucey (2021:239) lamented that there are reports showing that various healthcare professionals got infected with COVID-19 during close contact with COVID-19-infected patients. Physical and emotional stress resulted in several psychological and mental illnesses among healthcare professionals. The COVID-19 pandemic put healthcare professionals in a critical situation that needed to be considered a high priority public health responsibility for infectious diseases; their roles and responsibilities put them at high risk of infection (Fawaz, Anshasi & Samaha 2020:1341). The pandemic hurt the personal and family lives of registered nurses as it caused fear of being infected and later transmitted the infection to family members (Catania et al 2020:408).

4.4.2.2 Category 2.2: Patient concerns reported by nurses

The registered nurses in a general medical ward verbalised some concerns of patients diagnosed with depression who also tested positive for COVID-19 during the hospital stay. Some patients told of their fear of dying and others felt isolated because their families, friends, relatives, colleagues, and religious leaders were not allowed to visit the ward due to COVID-19 regulations. The drastic changes were overnight without proper communication with the public. Patients had only healthcare workers around them; they were also seen behind personal protective equipment, which deprived both the patients and the healthcare workers of reading facial expressions.

4.4.2.2.1 Fear of dying

Patients had a greater fear of dying during the COVID-19 pandemic and would misread 'normal' nursing actions as omens of bad news. They also feared being infected by nursing staff or other patients.

> *Patients were also asking me, 'sister, why are you coming to my room? I am going to die, and I don't want you to die". [P6]*

> *Dying of patients mhh, all the wards were turned to COVID-19 units, patients with depression even feared that nurses will infect them and die. [P5]*

> *Sister this last wave was the worst, one patient became more scared of death because his neighbouring patient died after active resuscitation failed. [P8]*

According to Yardley and Rolph (2020:1), patients with COVID-19 in a general medical ward had no time to deal with death as a possible result after a rapid decline in health status. The patients had to face death alone, without prior discussions on the possibility of dying with family or religious leaders. The diagnosis of COVID-19 brought fear worldwide (Ahorsu, Lin, Imani, Saffari, Griffiths & Pakpour 2020:1). In a general medical ward, a registered nurse mentioned that a sick patient even tried to protect her by telling her not to come to his room because he would die, and the nurse should not die. Aydin and Fidan (2021:12) stated that fear and anxiety caused by thinking of dying have escalated during the pandemic and death anxiety has been implicated in the development

of many mental disorders. A study by Cheong, Ha, Tan and Low (2020:164) found that nurses dealing with death anxiety may experience adverse reactions when caring for dying patients.

COVID-19 unveiled threats to human beings due to persistent tokens of death, representation of death figures due to COVID-19, and daily transmission statistics (Menzies & Menzies 2020:1). The belief is that there are diverse elements that increase fears related to the pandemic and cause death and misery due to COVID-19 being a challenge. The intense fear of dying results in anxiety associated with COVID-19 and causes several mental disorders including depression (Menzies & Menzies 2020:8). Khademi et al (2020:347) added that patients with COVID-19 have a fear of death resulting from lack of knowledge about the mysterious nature of COVID-19. Aydin and Fidan (2021:2) posited that fear of death is one of the major considerations that nurses felt throughout the COVID-19 pandemic. Such fears led to mental disorders.

'No patient is safe unless the healthcare worker is safe' (WHO 2020). The risk of COVID-19 infection among healthcare workers and the transfer of the virus to their clients is minimised when healthcare workers are adequately provided with personal protective equipment (Chand, Lal, Prasad & Mamun 2021:2). Patients can be kept safe and healthcare systems can be stabilised, only when healthcare workers are safe. Insufficient resources cannot be the reason to provide healthcare workers with inadequate protection against risks to their well-being (Shaw, Flott, Fontana, Durkin & Darzi 2020:1542). During the COVID-19 pandemic, the importance of healthcare workers was highlighted in all healthcare facilities and the protection of healthcare workers took hold of a tender spot consisting of a long-standing problem affecting patient safety (Dharmshaktu 2021:157).

4.4.2.2.2 No visitors were allowed for COVID-19 patients, creating additional feelings of isolation

The patient's friends and family play a vital role in recovery. Without this social support, both the family and patients could experience loss more severely, and the cost of losing social contact is more depressing.

> *And the stress was that the families would get a call that the patient has just passed on and yet they have never seen them, and then it was frustrating cause it's better*

if they would come and visit and see the patient's condition deteriorating, their hearts would be satisfied. [P4]

Because number one, now they are hospitalised, there are no visitors allowed for a covid patient, so that in general is very depressing for a patient and me and on top of that I can't engage with the patient. [P3]

I mean like family has a strong contribution to inpatient care such as telling you the full history about the patient, the pandemic deprived us of contact with the family due to social distancing, there was no proper history taking sister. [P8]

Family members, friends, and relatives of patients are acknowledged because they play a crucial role in providing patient-centred health and care to a patient. The accommodation of visitors in healthcare facilities enhances effective communication (Munshi, Evans & Razac 2021:3). According to Qian and Jiang (2020:260), social distancing is criticised because it exposed patients to depression and anxiety, meaning that healthcare workers, patients, and their families were psychologically affected. Patients with depression in a general medical ward lacked social visits from their spiritual and community supporters during their hospital stay, due to COVID-19 social distancing rules.

Hugelius, Harada, and Marutani (2021:4) argued that the restriction of visiting time in a general hospital led to feelings of loneliness and increased levels of depression and aggression in patients diagnosed with depression in a general medical ward. The application of 'no visitors allowed' in healthcare facilities is frustrating but cannot be avoided. It is a painful situation for the patient's family members, friends, and relatives not to see their dying family member.

4.4.3 Theme 3: Recommendations

Recommendations suggested by the participants indicate an need for management support, to ensure the safety of a patient, fellow patients, nurses, and all other members of the multidisciplinary team, and specific risk management strategies for the general medical ward.

4.4.3.1 Category 3.1: Registered nurses need hospital management support when managing patients diagnosed with depression in a general medical ward

Registered nurses need support, as the management of patients with depression could potentially be emotionally, psychologically, and often physically traumatic due to the behaviour of the patients during hospitalisation in a general medical ward.

> *Once upon a time, the management should organise some counselling sessions because we as staff, as nurses, who have a lot of issues, not our issues, issues about our work, where we will brief, where we will vent out, talk about what is going on in the unit. [P5]*

> *According to the management you were supposed to check on the patient, the patient did not just cut himself with a knife, you should have noticed that this patient is a psychiatric patient, the management did not treat us as nurses fairly, we were blamed, forced to write statements. [P2]*

> *I understand that sometimes management sounds to be less supportive or understanding of the situation. We can stop lots of problems with patients with depression in a general medical ward if only management can listen to us, as nurses on the ground. [P8]*

Aggression and suicidal tendencies become the most frustrating behaviours of patients to healthcare personnel (Hessler, Schaufele, Hendlmeier, Junge, Leonhardt, Weber & Bickel 2018:3). Foye et al (2020:407) described that patients diagnosed with depression in a general medical ward tend to receive poor management due to the lack of supportive leadership of registered nurses who provide direct patient care. Emotionally, registered nurses find it difficult to manage patients diagnosed with depression who have a history of suicide attempts. Support from hospital management is necessary because some nurses would decide to walk away from suicidal patients due to depression.

A lack of support for registered nurses harms their mental stability and determination (Mitchell 2022:2). The support of the top management is an important component of productivity in the workplace, as also identified by professional nursing organisations. Registered nurses should identify the role behaviours that establish top management

support. Management is required to develop policies and guidelines to support nurses' collaboration with patients diagnosed with depression in a general medical ward.

The guidelines will assist registered nurses to work in collaboration with all members of the multidisciplinary team. The lack of collaboration among multidisciplinary teams creates a distance for patients diagnosed with depression, and registered nurses are discouraged from treating patients with depression in a general medical ward.

Registered nurses experience a burden when hospital managers do not provide support in managing patients with depression in a general medical ward (Senek, Robertson, Ryan, King, Wood, Taylor & Tod 2020:5). The lack of adequate staff leads to improper assessment of patients upon admission and during a hospital stay. Jimenez, Burleson, and Hough (2021:280) highlight that nurses need supportive leadership in nursing management when managing patients with diagnosed depression in a general medical ward.

4.4.3.1.1 Ensure the safety of a patient diagnosed with depression, fellow patients, nurses, and all other members of the multidisciplinary team

Participants highlighted incidents of patients who attempted suicide during their shifts in a general medical ward. Nurses did not know whether patients were diagnosed with depression. Patients also posed threats to other patients and members of the multidisciplinary team.

> *One of the patients cut herself with a knife that was amongst her lunch utensils. She was amongst other patients when she attempted suicide, we were notified by other patients, when we came there was blood all over the linen. [P2]*

> *I got such a fright myself when I learned that one patient diagnosed with depression came out of her bed and went to bite a patient lying on her opposite bed when I was on night shift. The other patient was in deep sleep when she woke up with another patient biting her on her left arm. [P1]*

> *The problem is that patients diagnosed with depression sometimes get so irritated very easily, they are so dangerous to both their fellow patients and healthcare*

personnel, they come with so many stresses then as nurses it is like we are punching bags because you must accept that person as she or he isn't. [P4]

It is crucial that registered nurses who treat patients diagnosed with depression in a general medical ward be provided with detailed knowledge of all patients for safety in the unit, without breaching confidentiality. The researcher witnessed that patients diagnosed with depression in a general medical ward are placed amongst other patients with only physical illnesses. Implementing organisational values, policies, and guidelines can promote the safety of all inpatients and staff (Locke, Bromley & Federspiel 2018:12). Hospital management should create administrative recommendations and obligations to communicate to staff and support victims of patient violations, such as establishing a rapid response security team to assist. Nursing management should acknowledge and accomplish its assistance in patient interaction by supporting nurses and all healthcare personnel in safety management while providing bedside nursing care to aggressive patients or patients with behaviours that emotionally harm staff and neighbouring patients. The hospital management should set out prerequisites to avoid violence in a general medical ward with a patient diagnosed with depression (Vandewalle, Malfait, Eeckloo, Colman, Beeckman, Verhaeghe & Hecke 2018:877).

The unit manager and staff would base the unit rules on organisational values and guidelines to ensure the safety of all patients and employees (Pelto-Piri, Wallsten, Hylén, Nikban & Kjellin 2019:2). Registered nurses who manage patients diagnosed with depression in a general medical ward often verbalise anxiety as a burden for patients, and staff safety is regarded as their responsibility. Nurses and patients may view safety rules in the ward as restrictive, but policies and standards help to maintain safety in the unit (Slemon, Jenkins & Bungay 2017:7). There are strange actions related to psychiatric problems that involve self-harm, injuring fellow patients and hospital employees. There is a need to protect the patient, fellow patients, and staff from psychological and physical harm (Chai, Luo, Wong, Tang, Lam, Wong & Yip 2020:136).

4.4.3.1.2 The hospital management to establish specific risk management strategies for the general medical ward

Management risk strategies should start with admission documentation that screens each patient for depression. Here are some participants who mentioned that they were not

aware that patients were admitted with depression as a comorbidity because the patient did not disclose depression during history taking.

> *There must be special charts for patients that need close monitoring of their mental health status so that they can be checked thirty minutes or hourly depending on their mental status because others you can see that this person looks dangerous to himself or others are normal but there is some mental problem, so I suggest maybe to have a chart for a mental status of a patient to be monitored. [P4]*

> *If patients could meet us halfway, telling everything either good or bad, so that they could be documented on admission and patient get help regarding depression so that as a nurse you assist in knowing what is going on with your patient. It is so sad to nurse a patient you don't know. [P5]*

> *I believe, for me, the manager was once in my shoes but when they go into management, they forget about how I was there, how was it? They just forget about it and say a depressed patient in my time may be walking bedridden. Nowadays patients diagnosed with depression act. [P3]*

Slemon et al (2017:1) highlighted that safety in mental illness includes an uninterrupted analysis and management of risks both actual and potential. Designing assessment tools that support the detection of a patient's mental status on admission and during a stay in a general medical facility is necessary. Registered nurses provide support to patients diagnosed with depression in a general medical ward and ensure that the respect and dignity of the patient and their family are always maintained. There are ethical dilemmas that govern registered nurses' management of patients diagnosed with depression in a general medical ward. Registered nurses have been torn apart between institutional demands for physical and emotional distancing and compassion, which quality nursing care promotes (Babaei & Taleghani 2019:213).

4.5 SUMMARY

The registered nurses verbalised challenges in managing patients with depression in a general medical ward. The challenges came from various sources. There is the greatest possibility that patients diagnosed with depression remain unknown in the unit. Registered nurses raised concerns about nursing documentation that does not allow

proper assessment and description of patient mental status upon admission. Patients with depression as a comorbidity with physical illnesses were described as difficult to provide nursing care for, as the primary focus of suicidal attempts by patients that traumatised registered nurses.

There is no arrangement for psychiatric courses and no regular in-services for registered nurses. There is a severe staff shortage, made worse by staffing acuity tools that are not adjustable when the general medical ward admits patients with depression. Registered nurses verbalised that there was a lack of support from hospital management in the management of patients diagnosed with depression in a general medical ward. The lack of support from management was mainly due to a shortage of nursing staff, registered nurses would like to have enough nurses in a shift so that some of the patients diagnosed with depression can be allocated to one single nurse. The next chapter will discuss the recommendations, limitations, and conclusions of the study.

CHAPTER 5

RECOMMENDATIONS, LIMITATIONS AND CONCLUSIONS

5.1 INTRODUCTION

This chapter concludes the study. It includes a summary of the findings and how the findings met the research objectives to answer the research question. Recommendations are proposed to manage patients diagnosed with depression in a general medical ward. Contributions of the study, research limitations, and concluding remarks are provided.

5.2 SUMMARY OF THE STUDY

A summary of the study objectives and findings is provided.

5.2.1 Research objectives

- Explore and describe the experiences of registered nurses in managing patients diagnosed with depression in a general medical ward.
- Identify potential opportunities for improving the nursing management of patients diagnosed with depression in a general medical ward

5.2.2 Summary of the findings

The findings indicated that detecting depression on admission or during a hospital stay in a general medical ward is problematic for registered nurses. Specific aspects increase the difficulty. Nurses had a lack of training or experience in psychiatric nursing. A lack of staff led to poor patient evaluation, and patient acuity tools limited the number of staff available to care for patients diagnosed with depression in a general medical ward. Nurses experienced hospital management as unsupportive. The COVID-19 pandemic added additional complexity to the provision of care, and the vulnerability of nurses themselves came into play when patients were admitted with COVID-19, as well as other medical and psychological conditions.

The nurse-patient relationship was compromised due to social distancing, additional staff shortages, as well as a shortage of protective clothing. In turn, patients equally had death concerns and suffered an additional burden due to social restrictions brought about by the COVID-19 regulations.

5.3 RECOMMENDATIONS

The recommendations are provided in support of the following objective:

- Identify potential opportunities for improving the nursing management of patients diagnosed with depression in a general medical ward. The findings of the study of registered nurses' experiences in managing patients diagnosed with depression in a general medical ward propose several recommendations.

5.3.1 Opportunities to improve the nursing management of patients diagnosed with depression in a general medical ward

The study findings and the literature identified several opportunities to improve the nursing management of patients diagnosed with depression in a general medical ward.

5.3.2 Support from hospital management when managing patients diagnosed with depression in a general medical ward

Foye et al (2020:407) highlighted that patients diagnosed with depression in a general medical ward tend to receive poor care from registered nurses who provide direct patient care if supportive leadership is absent, which the findings of this study corroborate. Registered nurses experience an increased burden of care when hospital managers do not provide support in managing patients with depression in a general medical ward (Senek et al 2020:5). Registered nurses need support from hospital management, as the management of patients with depression could be emotionally, psychologically, and often physically traumatic due to the behaviour of patients during hospitalisation in a general medical ward.

Aggression and suicidal tendencies become the most frustrating behaviours of patients to healthcare personnel (Hessler et al 2018:3). Nurses require that hospital management

play a more supportive role when incidents such as those mentioned above, occur. Brooks, Dunn, Amlot, Rubin and Greenberg (2019:5) argued that employees that are affected by any workplace incident should be referred for counselling and psychological support. In addition, management should acknowledge that registered nurses are often witnesses of incidents and reliable sources of information. Heathfield (2021:1) highlighted that management should keep employees informed of the steps to take and the proceedings of the incident. The lack of collaboration among interdisciplinary team members could further isolate nurses, and registered nurses could become discouraged in the treatment of patients with depression in a general medical ward. A lack of support for registered nurses can also be detrimental to nurses' mental health and productivity (Mitchell 2022:2). Management support is an essential component of productivity in the working environment. In this regard, hospital management could develop policies and guidelines to support nurses in collaborating with all multidisciplinary team members, leading to a rapid patient recovery process (Reid, Escott & Isobel 2018:2).

5.3.3 Patient assessment and documentation during admission and hospital stay

The challenges that registered nurses experienced while managing patients diagnosed with depression were highlighted as starting with the documentation on admission that does not accommodate the detailed assessment of the patient's mental status, medical history, and treatment plan. The findings indicated that the information on the mental state of the patient was sparse. Tasew, Mariye and Teklay (2019:1) reminded one that nursing documentation is a written nursing care plan and care provided to individual patients by nurses qualified in the nursing unit. Admission of a patient to a general medical ward is a crucial moment for healthcare providers, the patient, and the family.

A detailed patient history should be provided by a patient or the family to the nurses in a general medical ward. Registered nurses can formulate the nursing plan and assign the nurse according to their ability to manage the patient. Registered nurses who receive information about a patient should follow a standardised questionnaire to obtain detailed information and complete a standardised form in writing or electronically. Failure of nurses to obtain a detailed history on admission leads to gaps in nursing care rendered to a patient. It is the responsibility of hospital management to construct the guidelines and standards that admitting nurses must follow in probing questions from patient and family

members. Patient history should be detailed and should include family-, surgical- and medical history, as well as medication and psychological history.

The standard of admission documentation should guide registered nurses in assessing the patient on arrival and changes in condition in a general medical ward. The hospital management should design an admission assessment tool with questions that require the assessment of a patient's mental status upon admission and during a stay with a special commitment to registered nurses. Nursing documentation helps to measure the quality of nursing care provided to a patient. Nursing documentation serves as a legal document to protect a patient and a caregiver. The daily nursing care plan must pay specific attention to the assessment, planning, implementation, and recording of the patient's mental state. The nursing documentation tool should not only focus on the physical illnesses of the patient.

Toney-Butler and Unison-Pace (2021:1) posited that the initial step of the inpatient assessment is based on an initial nursing assessment that helps collect data on the patient's needs. Subjective and objective data collection should be included in the patient's history. The nursing assessment helps nurses identify current and future requirements and set priorities. This may require more nursing staff with the necessary knowledge and skills. The document should also require an attachment to the signature of the admission nurse and the nurses who perform the patient's daily assessment as a sign of responsibility and accountability.

5.3.4 Ensuring the safety of a patient, fellow patients, nurses, and all other members of the multidisciplinary team

Registered nurses managing patients diagnosed with depression in a general medical ward often verbalise their anxiety about the burden that the safety of patients and staff is considered their responsibility. Vandewalle et al (2018:877) proposed that nursing management should acknowledge and provide their assistance in patient interaction by supporting nurses and all healthcare personnel in safety management while providing bedside nursing care to aggressive patients or patients with behaviours that emotionally harm staff and neighbouring patients. Locke et al (2018:12) argued that organisational values, policies, and guidelines should promote the safety of all inpatients and staff. The hospital management must create administrative recommendations and obligations to

communicate with staff and support those who experience patient violence by installing a rapid response security team. Hospital management should be proactive to avoid violence in a general medical ward with a patient diagnosed with depression. The unit manager should display organisational values, unit rules, and guidelines to ensure the safety of all patients and employees (Pelto-Piri et al 2019:2). Nurses and patients may view safety rules in the ward as restrictive, but the policies and standards help to maintain safety in the unit (Slemon et al 2017:7).

5.3.4.1 Mental health training

During the interviews, participants mentioned the need for psychiatric training to help gain a better understanding of mental healthcare problems and its management. The lack of in-service training in the management of patients diagnosed with depression in a general medical ward was described as a challenge. When nurses care for patients with mental disorders in a general hospital setting, they are required to take care of the physical, social, and psychological aspects of the patient; therefore, registered nurses in a general medical ward should be knowledgeable and well trained to care for the needs of patients diagnosed with depression in a general medical ward (Lowe 2019:1).

A course in psychiatric nursing would help general nurses understand the signs and symptoms of common mental disorders and the manner of communication that is applicable to the management of patients diagnosed with depression in a general medical ward. According to the study findings, registered nurses were uncertain about their level of knowledge, skills, and competence to manage patients diagnosed with depression in a general medical ward.

Registered nurses must be adequately assisted to acquire the necessary knowledge and skills to manage patients diagnosed with depression in a general medical ward and understand the connections between physical illnesses and depression as a comorbidity. Registered nurses gain confidence in dealing with patients diagnosed with depression if they receive in-service training and the opportunity to share their experiences. Bird (2018:3) highlighted that it is common for available nurses to define patients diagnosed with mental illnesses as complex and putting nurses at risk of assault and danger, so general nurses are required to become confident and competent in the management of patients diagnosed with mental health disorders in a general medical ward. The

researcher was encouraged by the enthusiasm of the research participants and their commitment to manage patients diagnosed with depression, if they are equipped with adequate mental healthcare knowledge by clinical facilitators who provide in-service training regularly in the unit. This drive and commitment must be harnessed.

5.3.4.2 Use of acuity tools

The study findings revealed that there are a high number of patients admitted to a general medical ward diagnosed with depression as a comorbidity with physical illnesses, as well as an increased number of patients diagnosed with depression during their stay. The level of staffing of the general medical ward and the acuity tools appeared to work against the workload of registered nurses. A lack of adequate staff leads to an improper assessment of patients upon admission and during hospital stay (Jimenez et al 2021:280). The hospital management should pay attention to the unit census and patient demands and provide a good number of nurses to cover the unit and ensure quality nursing care for patients diagnosed with depression.

5.3.4.3 Risk communication

The COVID-19 pandemic had a large influence on the study findings and many lessons could be learned from the pandemic in the future, as new pandemics or natural disasters can have similar demands. Risk communication is important in such instances. Norberg, Costa and Fowler (2022:629) highlighted that risk communication is a collaborative process to modify information and ideas among individuals, teams, and facilities. There are published guidelines from WHO, the United States (US) Center for Disease Prevention and Control (CDC), and others that outline good risk communication based on lessons learned from past health crises, including Ebola and Zika (Toppenberg-Pejcic, Noyes, Allen, Alexander, Vanderford & Gamhewage 2019:437). In times of crisis, new developments, plans, and adjustments must be communicated to nurses.

Scholz, Wetzker, Licht, Heintzmann, Scherag, Weis, Pletz, Betsch, Bauer and Dickmann (2021:3) found that risk communication is necessary for assessment and assessment selection of preventive measures. Therefore, risk communication plans play a vital role in implementing public health interventions. The WHO initiated several measures to provide public information in time on COVID-19 prevention measures. The WHO applied

innovative steps to improve risk communication throughout the pandemic. Announcements were made available to nurses through social media companies and Google searches of the WHO page.

Nurses' knowledge of the pandemic was also improved through online courses on hand hygiene devised by the WHO. The dimensions of risk communication must be reinforced in the regular work of registered nurses on a general medical ward. Anderko, Noonan and Volkman (2021:52) highlighted that unsuccessful risk communication results in poor patient outcomes and a waste of nurses' skills and efforts. However, successful risk communication helps counteract the development of complications and empowers nurses.

5.4 LIMITATIONS OF THE STUDY

The study was conducted in one general hospital only, and the findings cannot be generalised to other general hospitals, but the findings are transferable. The study sample was small but adequate to obtain the study objectives. The study was conducted in a general medical ward and not a psychiatric unit.

5.5 RECOMMENDATIONS FOR FUTURE RESEARCH

The COVID-19 pandemic led to an increase in major depressive disorder globally, and one can expect that this phenomenon could exist in future disasters or pandemics (Śniadach, Szymkowiak, Osip & Waszkie 2021:2). Improving depression care outside of psychiatric settings must be explored both quantitatively and qualitatively within evidence-based practice. The psychological adaptation of healthcare professionals during disasters should be carefully studied to establish proactive measures and support.

5.6 CONTRIBUTIONS OF THE STUDY

The study could contribute to greater knowledge and understanding of the experiences of registered nurses in the management of patients diagnosed with depression in a general ward. In addition, the study could help nursing education curriculum designers or in-service training providers develop specific curricula to establish nursing guidelines for the management of patients diagnosed with mental disorders in a general medical unit.

5.7 CONCLUDING REMARKS

The rate of depression has increased globally and is expected to continue as natural disasters and health problems increase. To address this mental health crisis, the shortcomings in the mental health system need to be addressed. This study explored and described the experiences of registered nurses in the treatment of patients diagnosed with depression in a general medical ward. A qualitative design assisted in answering the research questions.

The findings of the interviews with ten professional nurses indicated that the management of patients diagnosed with depression in a general medical ward was problematic in various ways. The COVID-19 pandemic further exasperated the inherent problems related to the poor training of nurses to deal with mental health issues, staffing, and patient and management issues. As a result, several recommendations were made to address these issues in the future. As front-line healthcare providers, nurses were often the unsung heroes during the COVID-19 pandemic, working tirelessly to care for patients, often at a high cost to themselves. We salute them and thank them.

5.8 RESEARCHER REFLECTIONS

I reflect on my research journey in conducting this study. This study increased my confidence in conducting the research. I will benefit significantly from increased self-confidence in the future as an individual, researcher, and manager. There is a lot of information I have come to know since I started this study, and this has helped me learn to write better essays, construct sentences correctly, and use the appropriate information for a research study. I have also improved my research skills by gaining insight into conducting research. I have read many journal articles on the management of depression by nurses in a general hospital.

My study was also hijacked by the period of the COVID-19 pandemic. As a front-line worker, I devoted most of my energy to the management of patients diagnosed with COVID-19 and taking precautions to protect myself and my family from contracting COVID19. As if a year was taken away from me, the years 2020 to 2021 were the crucial years of his study. I remember being busy with the research proposal during the lockdown

period, making declarations that I would survive this COVID-19 pandemic and reach the graduation period for this course. Most of the participants even brought in concerns about nursing during the COVID-19 pandemic, accompanied by feelings of gratitude to be among the living and to relate the challenges the nurses faced. I had an amazing time doing this research and I plan to continue studying and writing beyond this study. It was uplifting to have this opportunity and I cannot wait to see where it goes next.

I have learned to believe in myself, follow my passion, and not compare myself with others on their journeys. I have learned to create a research lifestyle that motivates me and to surround myself with people who motivate me. This research study has taught me patience; I am a person who is always in a rush, but great things do not happen overnight. Overall, I enjoyed the journey and have grown as an individual. I had to do a lot of introspection to discover who I am during this journey. My most extraordinary experience in this study is her excellency, my supervisor. My supervisor has encouraged, mentored, guided, and supported me throughout this time.

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ANNEXURES

ANNEXURE A: Ethical clearance certificate from the Research Ethics Committee: Department of Health Studies, UNISA

UNISA university of south africa

COLLEGE OF HUMAN SCIENCES RESEARCH ETHICS REVIEW COMMITTEE

14 December 2020

NHREC Registration # :
Rec-240816-052
CREC Reference # :
2020-CHS -42094577

Dear Miss Mandisa Mpetshu

Decision:
Ethics Approval from 14 December 2020 to 31 November 2023

Researcher(s): Miss Mandisa Mpetshu **42094577 @mylife.unisa.ac.za)**

Supervisor: Prof J.E. Maritz **(012 429 0000/ 082 788 8703)**

Title: ***registered nurses' experiences of managing patients diagnosed with depression in a general medical ward***

Degree Purpose: Masters

Thank you for the application for research ethics clearance by the Unisa College of Human Science Ethics Committee. Ethics approval is granted for three years.

The ***medium risk application*** *was* ***reviewed*** by College of Human Sciences Research Ethics Committee, on **14 December 2020** in compliance with the Unisa Policy on Research Ethics and the Standard Operating Procedure on Research Ethics Risk Assessment.

The proposed research may now commence with the provisions that:

1. The researcher(s) will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.
2. Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study should be communicated in writing to the College Ethics Review Committee.
3. The researcher(s) will conduct the study according to the methods and procedures set out in the approved application.
4. Any changes that can affect the study-related risks for the research participants, particularly in terms of assurances made with regards to the protection of participants' privacy and the

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Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
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confidentiality of the data, should be reported to the Committee in writing, accompanied by a progress report.

5. The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study. Adherence to the following South African legislation is important, if applicable: Protection of Personal Information Act, no 4 of 2013; Children's act no 38 of 2005 and the National Health Act, no 61 of 2003.
6. Only de-identified research data may be used for secondary research purposes in future on condition that the research objectives are similar to those of the original research. Secondary use of identifiable human research data require additional ethics clearance.
7. No fieldwork activities may continue after the expiry date **(31 November 2023).** Submission of a completed research ethics progress report will constitute an application for renewal of Ethics Research Committee approval.

Note:

The reference number ***2020-CHS-42094577*** *should be clearly indicated on all forms of communication with the intended research participants, as well as with the Committee.*

Yours sincerely,

Signature :

Dr. K.J. Malesa
CHS Ethics Chairperson
Email: maleskj@unisa.ac.za
Tel: (012) 429 4780

Signature : PP

Prof K. Masemola
Executive Dean : CHS
E-mail: masemk@unisa.ac.za
Tel: (012) 429 2298

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ANNEXURE B: Permission requested from the organisation to conduct a research study

Department of Health Studies
University of South Africa
PO BOX 392
UNISA
0003

The Nursing Manager
[redacted] Hospital
[redacted]
Krugersdorp

Dear Matron

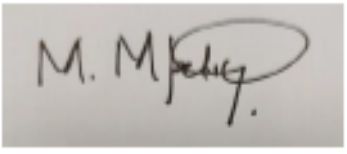
REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY

I, Mandisa Mpetshu, student at the University of South Africa, am currently engaged in a research study titled: **Registered nurses' experiences in managing patients diagnosed with depression in a general medical ward.**

I would like to ask for permission to collect the data from all the registered nurses who render care to patients with depression in a general medical ward. Only permanent registered nurses will be invited to participate research study.

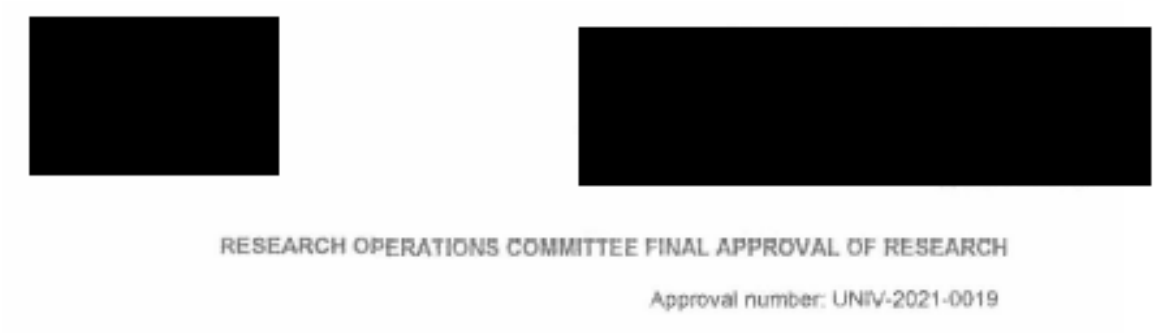
The study may assist hospital unit managers and leaders in understanding the registered nurses' experiences in managing patients with depression general medical ward and possibly identify potential opportunities for improving the nursing management of patients diagnosed with depression in a general medical ward.

You will receive a written report after the conclusion of the study.

Researcher's Name: Mandisa Mpetshu Signature: 

Date: 30 November 2020

ANNEXURE C: Organisational approval of research


[redacted]

RESEARCH OPERATIONS COMMITTEE FINAL APPROVAL OF RESEARCH

Approval number: UNIV-2021-0019

RESEARCH OPERATIONS COMMITTEE FINAL APPROVAL OF RESEARCH

Approval number: UNIV-2021-0019
Ms Mandisa Mpetshu
E mail: Mandisa.Mpetshu@[redacted].co.za

Dear Ms Mpetshu,

REGISTERED NURSES' EXPERIENCES IN MANAGING PATIENTS DIAGNOSED WITH DEPRESSION IN A GENERAL MEDICAL WARD

The above-mentioned research was reviewed by the [redacted] Research Operations Committees delegated members and if is with pleasure that we inform you that your application to conduct this research at [redacted] Krugersdorp Hospital, has been approved, subject to the following:

i Research may now commence with this FINAL APPROVAL from the [redacted] Research Operations Committee.

ii All information regarding [redacted] will be treated as legally privileged and confidential.

iii [redacted] name will not be mentioned without written consent from the [redacted] Operations Committee.

iv All legal requirements with regards to participants' rights and confidentiality will be complied with.

v All data extracted may only be used in an anonymised, aggregated format and for the purposes of this specific study as specified in the proposal. The data may under no circumstances be used for any other purpose whatsoever.

vi [redacted] must be furnished with a STATUS REPORT on the progress of the study at least annually on 30 September irrespective of the date of approval from the [redacted] Operations Committee as well as a FINAL REPORT with reference to intention to publish and probable journals for publication, on completion of the study.

vii A copy of the research report will be provided to the [redacted] Research Operations Committee once it is finally approved by the relevant primary party or tertiary

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Directors: [redacted]

Company Secretary: C Viksi
Reg. No. 1996/006591/07
institution, or once complete or if discontinued for any reason whatsoever prior to the expected completion date.

i [redacted] has the right to implement any recommendations from the research.

ii [redacted] reserves the right to withdraw the approval for research at any time during the process, should the research prove to be detrimental to the subjects/[redacted] should the researcher not comply with the conditions of approval.

iii Please note that you are:

1. Specifically made aware that this approval is granted to you on the basis of you being a permanent employee in good standing of [redacted]
2. Should you cease to be an employee of [redacted] at any time for the duration of the research study this approval granted to you for access to, analysis and/or publication of [redacted] data will be automatically revoked.
3. You are required to inform the [redacted] Research Operations Committee of the change in your employment status at [redacted] within 30 (thirty) days of you leaving [redacted] employment
4. You will be required to re-apply to the [redacted] Research Operations Committee for approval to continue with your research

APPROVAL IS VALID FOR A PERIOD OF 36 MONTHS FROM DATE OF THIS LETTER OR COMPLETION OR DISCONTINUATION OF THE STUDY, WHICHEVER IS THE FIRST.

We wish you success in your research.

30/4/21

Yours faithfully

[redacted]

Full member: [redacted] Research Operations Committee and Medical Practitioner evaluating research applications as per Management and Governance Policy

[redacted]

Chairperson: [redacted] Research Operations Committee [redacted] Hospitals (Pty) Ltd Date: 21/5/2021

[redacted]

ANNEXURE D: Participant information sheet and consent form

PARTICIPANT INFORMATION SHEET AND CONSENT FORM

Ethics clearance reference number: 2020-CHS42094577

Research permission reference number: NIV-2021-0019

Date: 06 July 2021

Title: Registered nurses' experiences in managing patients with depression in a general ward.

Dear Prospective Participant

My name is Mandisa Mpetshu and I am doing research towards a Master of Public Health, at the University of South Africa. Research study supervisor's name is Professor JE Maritz. I am inviting you to participate in this study.

WHAT IS THE PURPOSE OF THE STUDY?

I am conducting this research to explore registered nurses' experiences in managing patients with depression in a general ward and to identify potential opportunities of improving the nursing care of patients with depression in a general ward.

WHY BEING AM I INVITED TO PARTICIPATE?

I decided to invite you to participate in this study because you are one the general medical ward registered nurses. The registered nurses form the senior category in the general ward that admit, monitor, manage and control the nursing care in the ward. I obtained your details from the list of registered nurses in the list of nurses in the general medical ward.

WHAT IS THE NATURE OF MY PARTICIPATION IN THIS STUDY?

Should you decide to participate in the study, you will be asked to attend the arranged face to face interview with the researcher. This interview will take 45 minutes to an hour. The interview will consist of a grand tour question regarding your experiences of managing the patients with depression in a general ward such as 'How is it to you to manage patients diagnosed with depression in a general ward?'. Interviews will be conducted in English only. Interviews will be audio recorded using high quality microphone audio recorder after permission has been obtained from you.

CAN I WITHDRAW FROM THIS STUDY EVEN AFTER HAVING AGREED TO PARTICIPATE?

You can withdraw from the study at any time even after having agreed, without giving any reason and that will be without any negative consequences. If any data was already collected before withdrawal, it will be upon your permission if the data can be used. Participation in the study is completely voluntary and there is no penalty or loss of benefit for refusing to participate. You will not be obliged to divulge information you would prefer to remain private. No response will affect your employment negatively.

If you decide to participate on the study, you will be given information sheet to keep and be asked to sign a written consent form. You are under no obligation to consent to participation. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a written consent form.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

There will be no potential benefits of participating in the study, however, the information that you will provide will assist to gain in-depth understanding of the registered nurses' experiences in managing patients with depression or develop depression during their period of hospitalisation in a general medical ward. Information obtained from this study will potentially assist nurses, hospital, and unit managers to render optimal and holistic patient care to patients diagnosed with depression or develop depression during their hospitalisation in a general medical ward.

ARE THEIR ANY NEGATIVE CONSEQUENCES FOR ME IF I PARTICIPATE IN THE RESEARCH PROJECT?

There is no possible physical harm nor death to the participants in this study as strict COVID-19 measures will be taken. The potential of emotional and psychological discomfort is the only anticipation. You might experience emotional discomfort in expressing your experiences in managing patients with depression in a general ward. Should such emotional or psychological disturbances occur, the interview session will be stopped, you will be referred to the employee health and wellness programme. If you are still willing to continue with the study, the alternative date will be decided to carry on with the interviews The information you will provide during the study will not be used against you in any way.

WILL THE INFORMATION THAT I CONVEY TO THE RESEARCHER AND MY IDENTITY BE KEPT CONFIDENTIAL?

Confidentiality and anonymity will be maintained by reporting the findings without the use of participants' identity. The researcher will treat the information you provide as confidential. You will not be identified in any document, including the interview transcripts

and the research report, by your surname, first name nor by any other information. A code will be used in all documents. Pseudonyms will be used instead of real names.

The interview sessions will have one-hour space, if occur on the same day, to avoid participants seeing or bumping into each other and allow time to re-sanitise the room to prevent transmission of COVID-19 infections between participants. Your answers may be reviewed by people responsible for making sure that research is done properly, including, research supervisor, the transcriber, external coder, and members of the Research Ethics Review Committee.

HOW WILL THE RESEARCHER(S) PROTECT THE SECURITY OF DATA?

Hard copies of your answers will be stored by the researcher for a period of five years in a locked cabinet in her private place at home. The data collected for this research will only be used for this study and no other purposes. Information will be stored on a password protected computer and folder. Future use of the stored data will be subject to further Research Ethics Review and approval if applicable. After five years the information will be destroyed, hard copies will be shredded, and electronic copies will be permanently deleted from the hard drive of the computer using relevant software programme.

WILL I RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICIPATING IN THIS STUDY?

Participation in this study is voluntary, there will be no monetary reward nor any form of payment for participating in this study. In this study the registered nurses in a general ward will be given equal chances to participate voluntarily in the study.

HAS THE STUDY RECEIVED ETHICS APPROVAL?

This study has been approved by the Research Ethics Review Committee of the College of Human Sciences, Unisa. I shall provide you with a copy of approval should you wish would have one.

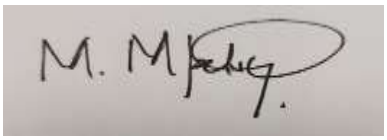
HOW WILL I BE INFORMED OF THE FINDINGS/RESULTS OF THE RESEARCH?

Should you be interested in study findings, the researcher will make available the study outcomes based on your request. If you would like to access the study findings, kindly contact Mandisa Mpetshu on 063 084 5225 or via email mmpetshu@yahoo.com. Should you require any further information about the study, feel free to contact the researcher, Mandisa Mpetshu, telephone number 063 084 5225 and email address mmpetshu@yahoo.com.

Should you have concerns about the way in which the research has been conducted, you may contact the chairperson of the Unisa, College of Human Sciences Research Ethics Committee via the administrator at mathama@unisa.ac.za.

Thank you for taking time to read this information sheet and for participating in this study.

Name of the researcher: Mandisa Mpetshu

Signature of the researcher:  Date: 06 July 2021

CONSENT TO PARTICIPATE IN THIS STUDY

I, _____ (participant name), confirm that the person asking my consent to take part in this research has told me about the nature, procedure, potential benefits and anticipated inconvenience of participation.

I have read (or had explained to me) and understood the study as explained in the information sheet.

I have had sufficient opportunities to ask questions and am prepared to participate in the study.

I understand that my participation is voluntary and that I am free to withdraw at any time without penalty.

I am aware that the findings of this study will be processed into a research report, journal publications and/or conference proceedings, but that my participation will be kept confidential unless otherwise specified.

I agree to the recording of the interviews.

Participant's name and surname…… (Please print)

Participant signature…….…… Date……

Researcher's name and surname…… (Please print)

Researcher's signature…….. Date……

ANNEXURE E: Interview guide

INTERVIEW GUIDE

How is it for you to manage patients diagnosed with depression on admission or develop depression during their hospitalisation in a general medical ward?

This will be followed up with:

Probes: ‘tell me more …’
Clarification: ‘please explain …’
Summaries: ‘In summary you said …’
Minimal verbal response: ‘carry on …’

ANNEXURE F: Interview sample

Participant no. 5

I-Interviewer

P-Participant

I Good afternoon.

P Good afternoon, ma'am.

I It's already now after … something to three now. So, thank you for being with me. The topic of the study that we are doing it says to explore the registered nurses' experience with regards to managing the patients with depression who are already available in a general medical ward. So, the study person is Mandisa Mpetshu, and that is me, and the supervisor is Prof JE Maritz, is one of the supervisors of [INDISTINCT – VOICE CLARITY] UNISA. We've been working together from last year, over this project. So, you've been invited on this study because we understand that you've got experience with nursing these patients in a medical ward, the patients that have got depression. You've admitted them, you've monitored them, you've managed them, and you've controlled their nursing care.

P Yes.

I So, your name is already known because you are in the database of the unit also. So, the study will assist the managers to render optimal and holistic [sic] patient care to patients diagnosed with depression or developed during their hospitalisation in general medical ward, and it will help them also to develop the right policies. It's a side of psychiatry in a medical hospital, in a general hospital. Not like we normal know that they are in the psychiatric [INDISTINCT – BACKGROUND NOISE – 00:01:22] but now in a general ward. So, this study, dear, you are not forced. So, if you want to withdraw at any time you are allowed to withdraw and there is no punishment, or nothing negative can be used against you. It's not an evaluation to check how do you perform your work, how do you know, it's not part of the test. It's just a talk. And, again, there is no [INDISTINCT – VOICE CLARITY], there's no benefits, so that after this study [INDISTINCT – VOICE CLARITY] get higher marks or you are going to get some money. No, there's nothing like that. So, the consequences, we don't have any harm. Some studies can have harm, like maybe you are given injection to test and then you can react. This one is not having anything. It's just me and you to talk. And again, you're gonna maintain confidentiality and anonymity. We are going to use your information not under your name, under a pseudonym. And then we're gonna

transcribe. I will keep it on my computer that only me can be able to open it, and I'm using a password. Once the study is done and everything has been done, we shall destroy everything. It's just because of the studies. So, then [INDISTINCT – VOICE CLARITY – 00:02:32] session we can just take our forty-five minutes to an hour but don't panic. Whenever it's finished, we are finished. As I told you, the study has been approved by the Ethical Committee of UNISA as well as Ethical Committee of [redacted]. So, it's an approved study that I should go ahead with it as a student. So, let's say you want to know something after the conversation it's fine. My number is zero-six-three zero-eight-four five-two-two-five, or you can use my e-mail mandisampetshu@[redacted].co.za or you can use the mylife one for UNISA or my personal one, mmpetshu@yahoo.com, if there's anything you want to clarify. And then that's it. Otherwise, thank you for coming and thank you for responding, and we can now start. So, back to the topic. I said the topic is registered nurses' experiences in managing patients with depression in a general medical ward. So, my question now is I want to know how do you experience that? How do you feel about it? How did it put you? You are already used to nurse your patients in a medical ward with medical conditions. Suddenly now there's this one now comes with a depression. So, what impact does that patient have to you as a nurse, and to your nursing care as well.

P First thing first, I'd say as patient inside the ward, others come with underlying condition whereby they are treated for that condition, and by having relationship with that patient you can end up picking up that the patient have got the problem due to … for example, when you talk to the patient, communication is so important to talk with the patient, that's where you'll pick up if this patient have a problem or not. Some patients [sic] you will find that even if you only want to give medication you'll have problem, they don't wanna take medication. That's where you'll pick up that this patient has got depression. Others would like to scream themselves inside the corner, inside the little cubicles, to be alone, isolating themself [sic]. Then that's where you will see that this patient is not okay. It's difficult to us as nurses because we have time management. When you come to the cubicle, you don't have one patient, you have several patients of which you must use your time correctly to cover all patients. So, if it happened that you have that patient who give you a task or who make you spend more time, it consumes all your time, so you won't be able to help other patient. For example, if I have five patients and I must give medication before ten o'clock, eight o'clock is breakfast. I know I have two hours to give medication. If maybe I will spend

forty-five minutes in one patient … because when patient talk you must listen, you cannot just block the patient. You must sit and listen. So, if maybe I cannot manage to sit down and talk to that patient, I won't get enough information about that patient. And progress of the patient. If patient can be open enough to talk to me, it can help me a lot because I will see the progress in that patient concerning the condition of the patient. Medication. When I give medication, is the patient taking the medication? Is there any change to that patient when taking medication? Because if the patient is taking medication, I should see in a few days that from day one to day three I can see difference in my patient. So, it frustrates us, it exhausts us. It sometimes makes us lose interest in what we are doing because the pile of work…it gives us a pile of work because I must squeeze other patient in that moment. I must help this patient, but I must take care of other patients. In so many cases, you find out that that patient it will need you to have enough staff to manage. So, if maybe you have short staff, as short staff is always the case in our institution, it will be difficult. You are running the unit, you're giving medication, you're taking care of the patient, now you have this patient. Your tea breaks, you won't have time for your tea breaks whereby it won't be okay for you not to go for your tea breaks. That's why you will be so tired. You cannot just work without going for tea breaks. Then you'll squeeze your time. It little bit rushing because now you're worried about the patient because I didn't talk enough with that patient. We happen to find ourselves working under stress environment due to that because I must cover. Maybe I will cover for the work, which is supposed to be done about three nurses, maybe alone. Sitting down with that patient, it's consuming my time. And by doing this, it causes stress to me. As a result, to me I see that's what it causes more illness to us as individuals, as nurses as well. Because when I have a patient who is not well, a patient who the condition stays the same, you stay with the patient for a week, there's no change, treating this condition, while there is another hidden condition which you don't know. Patients sometimes are…I cannot say is being clever because when they have that condition they know when you give medication you are not helping yourself, you are helping them, but they will try to…sometimes when you give a tablet, they don't swallow it, they put under their tongue. Then you are sure that the patient has taken medication while the patient didn't take medication.

I So, there's much supervision.

P Yes. Even if you can say can you please open your mouth, the others will feel offended by doing that. It's like you don't trust them. Why you are so on me? Why are

you checking on me? You have given me medication, I have taken them, why are you checking on me? But you're worried, as a nurse. To me, it gets to me, it gets to my family, because if I'm not happy at work, if I have stress at work, work-related stress, I'm not happy, it will affect me, it will affect my family as well.

I You must still go home.

P When I go home, I'm happy. I won't be happy at home as well because this environment is the environment I love. So, if I leave unresolved issues like this patient of whom I must help but I couldn't help due to these circumstances, it hurts a lot. So, I think that's kind of environment which cause stress which cause mental illness to nurses. If you can look around, there's a lot of mental problems, mental illness, to the staff, to nurses. It's not caused by our families; it is caused by my work environment. I spend twelve hours in this environment where I'm not happy. If I wake up in the morning, coming here to nurse a patient, only to find that I didn't win, it hurts because I didn't win. My goal is to come here and nurse this patient and win, see that patient walking out, not to upgrade her to ICU, walking out the door, going home. So, if the patients are now upgraded to ICU, it means I have failed the patient because the patient's not going home.

I He's going to ICU.

P He's going to ICU. It hurst to me as a nurse. It feels like I have failed that patient while it's not me, it's the condition, it's what the depression is doing to the patient and to us as nurses. When you have ten patients, your wish is to see them in five days/ten days all going home, not going to stepdown due to this depression. You start planning for the patient to go to stepdown because there is this problem, there is this depression on this patient. It's not good. It's not effective to you as a nurse. For me as an individual, when circumstances like that comes, I think we can get help from the management. In which way? The management should organise sort of counselling. Once in some time, they organise some counselling's [sic] because we as staff, as nurses, who have a lot of issues, not our personal issues, issues about our work, where we will brief, where we will vent out, talk about what is going on in the unit. Our timeframe is so, so, so conducive in a way we don't have time to talk. I come in the morning; you work. When you knock off, you rush home. When you're off, you wish to rest. So, there's no time for me as a nurse to talk. Even a knife, if you have a knife, you see that this knife is blunt, you must sharpen it. Even me as a nurse, I must sometimes be sharpened.

I Yes because you are drained.

P Yes. I must be sharpened. So, I think the management must organise a programme whereby all nurses must get chance to talk about what's going on in the unit for us to perform better, for us not to dwell on those illness we come across in the units. Patient with depression, sometimes you don't even acknowledge. When they come, you can't even see. But when you –

I On admission.

P Yes. On admission you cannot even see. Because what I have realised, patient with depression they are too private. They don't want to be known. It's like when you say you have depression, you're insulting them. It feels like you can have another word or another name for that. So, they hide it. They don't want you to know more because it's like when you know about that depression you want to know the source. It's like you want to know the source because –

I It's very interesting.

P … there can't be a depression without a source. So, that's why they are so private, they are so holding, they don't want anyone to know what's happening. And when you start to talk about that, you'll see they'll be aggressive. Others they will even say, ma'am, do you have any chronic conditions? No, I don't have any chronic condition. Then on the line, I want to take my chronic medication. Then you'll be like your chronic medication. Yes, I'm on this and this and that. Then you'll be like do you have depression? Then that's where they will see that by knowing the medication you know what this medication…others we catch them. When they run out of their medication, then they want the doctor to prescribe them because they see they cannot go and buy themselves medication. Then they want you to help the doctor to prescribe it. That's where you'll know. But at bottom line, patient with depression they happen … to us as nurses, they happen to make us feel like we are not doing all we are supposed to do because they are not giving us space, they are not giving us all information. Like I said in the beginning, it's sad because when it happens in the unit, the patient jumps through that window. The first person will be blamed is a nurse. Then it will come to me as a nurse. I will start to have stress, work-related stress, due to that incident report which I must sit down and write. That –

I Tell us what happened. Mm.

P … cause stress to me. What happened? Where were you when the patient jumps out of the window? There will be no question whereby it will ask how many are you when the patient jump from the window? No. It won't be like that. Where were you when the patient jumps from the window? Have you seen the patient jumping over the

window? Meaning that you were not around. First point. I'm not one-on-one with that patient. That won't be counted in that moment. I won't even mention that, that I'm not one-on-one with nurses.

I [CROSSTALK – 00:19:11] be very wrong to mention.

P Yes, I will be very rude when I say that. Fact or no fact, I will be very rude. But I must sit down and write an incident report of a patient who jump over the window and kill herself under my care. You understand that word?

I Yes.

P Under my care, patient died. Meaning there's something –

I And you are the shift leader.

P I'm a shift leader. On my hands, one patient slip and died, on my care. When you address that alone, it makes you feel like you are not doing your work properly. Unregardless [sic], the environment, how is the environment? So, that, it will cause stress to you as a [sic] individual. It will cause stress to your family. You will carry all that to your family and go poison them because now you are frustrated. Your frustration, you will take them to your family, to your community.

I Cause more problems.

P You have a lot of problems. To a [sic] environment … remember I say, this environment, I spend twelve hours. So, if our patient can meet us halfway, tell everything so that I can help them, good or bad. I'm taking depression medication, I'm on 123. I have other condition. I have [under? – 00:21:00] condition, I have bipolar, I have [that?], I have [that?], so that you assist knowing what's going on with your patient. It's so sad to nurse a patient who you don't know. When I say you don't know, whom you don't know all information.

I There was no transparency.

P Yes. So, it's so sad because where you should help you cannot help because you don't know. So, it hurt a lot…to me, it hurt. I wish in our unit they can create the environment … for example the windows, to make the windows in such a way … I don't know how, in such a way that no –

I No patient will jump.

P … [CROSSTALK – 00:21:58] or no person can jump.

I It's important [INDISTINCT – VOICE CLARITY].

P To our doors, to every door, I think no patient shall just walk out and in as they will. Nevertheless, [the main interest?] but the unit itself there should be someone…not that they are kids, they are not kids. Because I know that in paeds units they do, there

is security on the doors. But in adults, I wouldn't say unstable patients because it's a temporal thing which can be treated, and the patient can lead a normal life if they take the medication well. But I think they should be monitored in the way … the entrances, someone must be there, or a security whereby they check them, who is in, who is out. The most dangerous part, the smoking areas, that's where a lot of things is happening. Patient [sic] go out to the smoking areas, we do not follow them. We don't know what they're doing there, we don't know what are in their pockets, in their bags. So, a lot is happening there in the smoking areas. It's their right to smoke but I feel like those patients with depression there might be another way of helping the…I don't know how but declining them to go and smoke is not a good thing. But what I have experienced when they come back from the smoking areas they have changed. They would have changed. I don't know what is in the cigarette.

I Changed to the better or to the worse?

P To the worse. The patient is he [sic] will be talkative, is they will be…you cannot even control them. You cannot direct any order for them to do and they do. If they are inside a cubicle where they are three, they will start not to want to stay with other patients, they want to stay alone. A lot is happening on the smoking areas, which I don't know what it is. I wish I know. But I wish that can be corrected. I don't know how but, that, it must be corrected. Then came to this psychotic unit or hospitals. When I come to that point, to me … I don't know, maybe I'm too much … To me, it feels like a jail. It feels like we are discriminating from the environment, from the community.

I So, you like them when they are with us in the general hospital.

P I think when they are with us, they will feel that love, they will feel that touch, they will feel that they are not different to us. It's just that condition. But taking the…grouping them, putting them at the corner in that specific stepdown, in that specific unit, it makes even other people they'll know in that unit, it's a psychiatric unit, they know everybody who gets in there.

I So, [CROSSTALK – 00:25:50] psychiatric unit, even there in the hospital.

P Even in the hospital. If there is a psychiatric unit in the hospital it makes them feel that they are not okay at all, they are not well, they are different from other patients. To my opinion, it's like what if we don't group them in that corner? I don't know how we can do it, so that they can feel that they are still part of this community, they are still part of us. Because I think that alone, that's that make them angry. Because they can see that they are treated differently. Others are restrained. Some patients [sic] are restrained.

I Due to depression.

P Due to depression. Because if they don't comply, if you can see that they can cause some harm to themselves and to other patients, the doctor can prescribe restrain. Physicals restrain or sedation or other kind of restrain. So, that, I think, to them is discrimination. But it's for the benefit of them and to us and to other patients to be safe, not to harm other patients or not to harm themselves. But it feels like they are so discriminated. That's how I feel. For example, if you have…at home you have a patient with depression, then you'll keep on it's now time to take medication, then even the young ones they will know that now is the time –

[CROSSTALK – 00:27:24]

P It's the time to take medication.

I They will remind.

P They will remind you, like it's time to take medication. So, everybody in the family knows that eight o'clock you are taking your medication, eight o'clock after breakfast you are taking your medication or on that time you are taking your medication. That, it feels like you are different from other kids or from other part of the family. But you cannot take care of your own health, that's the reason they are reminding you. Because by yourself maybe you cannot even remember that you must take the medication. Your condition has worsened. You cannot think by yourself that now it's time to take my medication. You forget. But in other way it feels like you are being discriminated.

I Within the family members.

P There is a say whereby nurses who work in psychotic hospital they end up being like [INDISTINCT – VOICE CLARITY – 00:29:03] their patient.

I [INDISTINCT – VOICE CLARITY].

P I don't know how true that is. But when I think of that…I've never been there but when I think of that is that, like I said from the beginning, when you group them it's like when you're making fire.

I Making it worse.

P But if there was two or three, do you think we can scream that much? Can I scream that much as a nurse?

I No.

P But when there are ten, I will scream my lungs out the whole day. That's how I see it.

I It becomes even worse.

P Yes. So, to me, the fewer they are, is the much work to me, much better work to me. Because with that two/three I can manage them, but if they are too much, I will need hands to help me, of which sometimes it's impossible to allocate a specific nurse to nurse those patients. Mental illness to the staff, to the nurses, it's caused by the workload we have in our unit, especially a stressful unit whereby you have every day when you wake up in the morning deal with problems, deal with a patient who need your attention while you are short staff. You mustn't say you are short staff; you just have to do your work where you can, help them where you can. And another thing, I think the patient themselves they can be taught how to manage themself [sic] when they have that condition. I think that can make our work –

I To educate them.

P Yes. I think that can make our work much better if there is maybe health education on the patient how to manage themself [sic] if you have depression.

I So, there's [CROSSTALK – 00:31:30] management.

P He must be aware that it's not the sentence to have depression. You are still loved; you still have your family. You can still work when you have that depression. You can still get married and have your kids when you have depression. You are not different to other patients. It's just different condition.

I Hence you said before when we group them, we make them worse, because now they will see that now we are the ones who are depressed.

P Exactly. So, I think that can reduce mental illness to the nurses because, if can evaluate nurses out of ten, maybe you can get three normal nurses who are healthy.

I Out of ten [CROSSTALK – 00:32:35] only three.

P Out of ten. Category by category we're getting down.

I I'm just interested now, is there any means that really are done to check on the nurses' mental status?

P Sister, I think –

I Or to accommodate?

P I'm sorry to say this, I think the management have forgotten that we as nurses we are still human beings. I'm sorry to say that.

I It's fine. So, talking about this pandemic now, suddenly, we're nursing nicely, nursing is our job, it's our calling –

P Yes, we love nursing.

I We love nursing. Suddenly, last year, a monster hijacked our profession. COVID-19, it has come. It has affected people but for us as frontliners or for us as nurses it's more real because people came to us and even some of us died with this pandemic.

P Yes.

I So, what I want to know now, for you, on your uptake now, because COVID-19 has caused depression, both patients or families and us as in family. So, it has affected us.

P Both of us.

I So, on your experience now, [what really? – 00:33:53] happened, because let's say one patient came here and is having COVID-19 or maybe was first PUI, tested for COVID-19, then now you have to go now and bring the news on the patient that you are positive, and this patient is a sixty-seven-year-old lady and is already having husband who is seventy-two years at home, and is having children and grandchildren that they are living with, the whole family is living with her. So, that means that now not only that is positive, but you must also follow up and test those people that are home. So, how do you handle that situation now, as a nurse, a registered nurse? I've got this patient like this now. And above this COVID-19 she's also having a diabetes.

P If a patient like that come in the unit as a senior, you find out that the patient is COVID-19 positive, you must take care of that patient to address the matter because now you must take that patient from that PUI to a red zone, prepare the patient first. Because sometimes we happen just to…we don't address the matter nicely to the patient. That as well traumatise the patient because we're taking the patient from this –

I Yellow zone.

P … yellow zone to that red zone. Now it's much better. I see they don't cover them. I feel sad last year how they were being handled, COVID-19 positive patient, how they were being handled, because they will cover them even with plastic, they will put a lot of stuff. At first, we as nurses, I think we were supposed to be prepared. We come to this COVID-19 unprepared, not knowing what exactly we are facing. I think there were a lot of things which we were supposed to do but we didn't do because lacking knowledge, fearing of our life, to help that patient. So, I must address that patient, not scaring the patient, address the patient, do a follow-up of the family. Because it won't help me to treat this patient not knowing what's going on at home. Because I will treat this patient, she gets well, go back to COVID-19, and come back again if lucky. So, I must do follow-up the family, the husband, the kids, for them to go test so that when

they are positive as well, they can go get treated. Other senior citizen, at home there's no-one to take care of. That as well I must check. When I discharge this patient, where does this patient go? Who will help this patient? Because they don't discharge you when you're already fit, running. No. Because lack of space. So, when you're better, they discharge you. So, I must do follow-up as nurse. Who will take care of you when you're going home, *gogo*, as you are a senior? Then so that someone must take care of you, to give you medication, to make sure that you are taking the medication correctly at home. And the environment, is the environment conducive for you as a patient, where you stay? Maybe you're staying with the young ones or maybe you are staying alone. So, COVID-19 people know that COVID-19 it's more dangerous than any condition because it kills you. In short period you can die. If I have an [sic] oxygen, I can die. Why? If I'm not connected to that oxygen, I can die looking to that oxygen without anyone helping me to get that oxygen. I have naps. If no-one's helping me to get that nap, who will help me? So, they need assistance, even at home, because this continuity of care it doesn't end here. It goes until at home. So, I must make sure that this patient physically, emotionally, is fit to go home to the environment. We must prepare the patient to go home in a stable condition, physically, emotionally, because that as well it cause this depression. Everyone is afraid of death. We know this COVID-19. Others even say I don't have money to buy sanitiser, I don't have money to buy those vitamins. So, if COVID-19 is struck in that family, it means that family will die because they won't be able to buy one, two, three. Mask, for me, if maybe I oversee this, those unprivileged families should have free mask because if I can't have money to buy food what about to buy mask? That's why. What I know –

I [CROSSTALK – 00:40:07] priority.

P Yes. What I know, they wear this mask for a week because they don't have money to buy masks. I can't throw this mask because I don't have any money to buy another one. So, they will keep wearing this mask until this string is torn. So, poverty as well, it contributes in this because they don't change their mask. They're wearing one mask for seven days, wearing one mask because they cannot afford to buy another mask. So, especially to the elderly. Lack of knowledge, not understanding what it is. So, when they're home, they don't know what to expect at home. They don't even know how to handle other family members with COVID-19. For example, if my husband is positive, I'm negative, when you tell him you must isolate it's like it's a divorce. It feels like a divorce, but you say you said you would do with me no matter what. COVID-19 or no COVID-19, you should –

I But then you must both die now.

P Knowledge if you educate them. So, look here, my love, you have COVID-19, you must isolate. You will be in that room, and I will assist you with everything you need. For this certain period, you will be there alone. So, knowledge as well. We must arm our patient with knowledge because others they come, they get treated, they go home, they come again with COVID-19 again. That means that we didn't do enough of our work. Educating them on discharge.

I So, it means at discharge education can relieve the depression.

P Yes. So, we didn't educate them when they go home. So, they will come back again with same condition. That alone means that we must educate them, if you have a chance, because you might not have a chance to teach that [INDISTINCT – VOICE CLARITY – 00:42:38] on the street. But the one who is brought, the one you admitted, you have full time to teach, to educate. When as you have COVID-19, I even tell them I don't wanna see you here again. I tell them personally. I tell them I don't wanna see you again. For example, when giving medication to those elderly, sometimes they don't comply. I just become personal. I say I'm here to help you. Unfortunately, I cannot take this medication for you. If I will, I should have taken this for you, but I cannot. You must take this medication for you to go home. Do you wanna stay here? This little bed you are sleeping, is it nice? You leave your queen at home to come sleep in this little bed.

I Sleep in this thing.

P So, all I think is to enrich them with knowledge, young or old. If we keep on talking, keep on reminding them, I think they can learn one or two. So, the state of depression I think can subside to them.

I That's nice.

P So, I think about this COVID-19 because COVID-19, as I said, to poor communities it's really striking high, reason being … I'm just thinking as I know, these community, in the house, it's a four-room house, you are eight. So, if it's a four-room house, you are eight, one gets positive symptom, COVID positive, the whole house … But if it's a four-room house, you are two, so it means only two might or may not –

I It might even be one.

P … because you have space. So, that's why I say poverty contribute in this as well.

I That's great. That's very bombastic. So, as a registered nurse, it means that we should also be challenging the registered nurses to be able to educate, because I heard that you emphasise education. So, it means even if they are in the ward, as

you mentioned that upon discharge, you even said if you don't educate them upon discharge, we are going to see them coming back.

P Exactly.

I So, which means we need to also equip each other about that. And then the management, you also mentioned that the management also needs to help us. Because there's nothing in place, like documentation, assessment, like when the patient comes in, how do you assess on their documentation sheet. So, I think we need to get that right as well. And, again, to measure that we've got enough staff because as much as you are willing to teach them…I mean to nurse the depressed patient and to give them time, explaining, but still for this other twenty-nine patients that is also waiting for the piece of you over these two hours of giving medications. So, I think we need to check also on the acuities.

P Yes.

I At the same time, the registered nurses should be able to assess the patients and be able to support the need for staff. The management are not going to go to the ward and check but if we assess and then we say in this ward we've got this one who is confused, who can jump the window at any time, now that the windows are not yet fixed, who can jump the window at any time, probably she needs a one-on-one nursing care. I think we can be able to override the staff and put more staff and be overstaffed to save life than to say we want to be four, we're gonna know that we're not gonna make it, we're gonna end up losing a life if we are four.

P Another thing, Sister, which just come into my mind. In this situation, especial [sic] for this COVID-19 we are in, there's no specific policy of which it guides us how to handle patient with COVID-19. It's just talk about patient in general, not specifically for COVID-19 patients, of which we can find out that if maybe there is a policy … I know this is temporal. As it is temporal, it's causing a lot of harm. But I think if maybe as temporal as it is, there should be a policy whereby it will guide us how to work and how to handle those patients. Because we as nurses, if it happened that we lose a staff on COVID-19, it breaks us into pieces. It really breaks us because when I'm home thinking of coming to work to that red zone, no longer wearing this white shirt, wearing that PPE, it's stressing, it causes depression to us as nurses. Wearing that PPE alone, wearing it alone, not going inside that fire, going to the patient. I have realised that patient who have COVID-19 they think we as nurses who are positive, we are negative, we are also positive because … they don't mind. Even if you say, sir, can you please put on your mask? They want to talk to you but they want you to

come closer, but they don't wanna put their mask. And when you tell them to put mask it's like you are being rude, but they know very well that there must be a social distancing, much better if you have mask, I can come closer if you have mask. But it feels like you hate them, you're discriminating them.

I [INDISTINCT – VOICE CLARITY – 00:49:12] that they have seen so many people dying of COVID.

P Yes. And another thing which drive them crazy, to see other people dying. At ED you can see anything happening. In ICU it's worse.

I Even in the wards.

P In the wards it's worse. You see things. We hide them until we can't hide them anymore. Because while you're still helping this one, this one deteriorates. So, it causes depression to them. Others they get depressions by the hospital, others they come with depression in the hospital. It come in different forms. Others are depressed due to financial problems, I don't have medical aid, I'm sick, I must pay the bills. That's where depression comes in, because now I must pay. I want to be treated here at [redacted] but I can't afford to be treated here.

I I must go to government.

P I must go to government. That causes depression.

I It's a wide topic, and the reason about depression it also becomes important because it affects the caregiver and the patient.

P Like I said.

I So, happening on the same …

P [INDISTINCT – VOICE CLARITY – 00:50:34].

I Same thing as the COVID.

P Yes. But you've [INDISTINCT – VOICE CLARITY].

I Ja. The COVID, it affects the patient and the one who's giving the care to the patient.

P I even joke one day. I say, here, the patient came with IV from ED. It tissue. I must insert EV [INDISTINCT – VOICE CLARITY] V. Tell me about social distancing then. I must come closer. I'm negative but I must come closer for you to receive your medication.

I Now with medication it becomes worse because they remove them.

P They take it out. Each and every time you want to do IV [CROSSTALK] –

I Especially ones who must put [INDISTINCT – VOICE CLARITY] four times a day, because it keeps on removing them and there's so many antibiotics that are given IV on this patient.

P You have to give. So, when you come in the morning, we'll be like…they'll say Mr So-and-so have taken out the drip, then you'll be like, oh, my God, you are not…you don't say, oh, my God about putting the IV, it's because you know you must come closer to the patient and the patient is positive, COVID positive.

I And, still, even if you are … we're not even [INDISTINCT – VOICE CLARITY – 00:51:44] enough. He wants you to come closer.

P Closer, you must come closer. Even for you to work nicely, it needs you to be closer –

I To be comfortable.

P … holding the arm of the patient closer and insert the jelco nicely. So, really, we both, patient, and the staff, we're in same boat. We are all depressed.

I These days, you are a nurse at your own risk.

P We no longer plan, we're no longer happy. I used to love wearing a uniform going to work but nowadays … I have one day even feel have I chose the wrong career? No, I didn't choose the wrong career.

I It's not [INDISTINCT – VOICE CLARITY – 00:52:32].

P [INDISTINCT – VOICE CLARITY] career.

I It's just the moment.

P It's just this moment. And I sometimes feel like I have saved one, two, three, I have done my work one, two, three, I have lost one, two, three, but it's not all in my power. If everyone can listen and go get the jab, maybe this can pass.

I And try not to modify your life completely. Maybe two months and three months then we can be done.

P And for patients who have been in hospital, I think them as well. To each and every patient who pass through me, I tell them.

I When they go home and teach.

P [CROSSTALK – 00:53:22] when you go home, sit down with your family. I say have you enjoyed staying here. Is it nice to have Covid? Is it a nice thing to have COVID-19? Then you say no. I say save your family then. If you think coming here is not nice, so save your family.

I No-one else must come from your family now.

P Save your family. Go save your family home. If each and every one can save their family, we can be all safe.

I And we can all be safe.

P And we as healthcare workers, we can be safe. We'll be stress-free then. We love coming to work.

I That's true.

P So, depressions come in different forms, and it affect us differently.

I The answer of depression is like one has got depression then the other one gets it.

P Yes. We pass it through, from one person to another.

I Imagine now it's already now a year and a half we are dealing with this thing of COVID-19 and who knows what next.

P Only God knows. We don't know.

I So, we better be finding a way, the ways of coping with it now.

P Yes.

I Otherwise we're gonna all become depressed.

P But long ago they've educated people on HIV and AIDS, and they won. Even now, if you cannot get tired of teaching, I think we can win as well.

I And then comply also with the vaccines.

P And vaccine –

I Vaccine has helped many countries already by now. But even that vaccine as well, we need to teach people to take vaccine because we've got people who are resistant to take vaccine, who are hearing stories that so-and-so died and nah-nah-nah.

P This should be an individual decision. Each and every one must learn to take care of herself or himself. I'm not doing this for my friend, I'm doing this to save myself and my family. It's about me. It's not about what other people are saying. How do I understand it? I mustn't answer like I heard so-and-so saying like this about this vaccine. I must check what benefits do I have to this vaccine?

I That is true.

P Then we'll be a free country, we'll be free healthcare workers.

I Let's hope that we won't have the fourth wave.

P Let's hope so.

I The third wave was so bad; I cannot tell you.

P It was really bad. You only find that eighty percent of the hospital is red.

I, even more than that. Even ninety percent.

P Ninety-five.

I Only the maternity was left now in these times.

P Not maternity. Not all unit. Even the maternity ward is red. Because they will take patient, red, red –

I Red maternity patients.

P Yes. Even here in [CROSSTALK – 00:56:22] –

I But the paeds ward was just having the adults, positive patients.

P Adult, paeds ward, paeds ICU, ICU, they will take paeds to medical, share maybe this is for paeds, this is for adult patient. All the units. And we cannot have vent all the hospital health ventilated patient.

I It's uncalled for.

P [INDISTINCT – VOICE CLARITY].

I It's uncalled for. There were not even nurses actually.

P That's a problem. And our staff are dying.

I Care workers had to nurse patients and get [INDISTINCT – VOICE CLARITY] the IV antibiotics because now there's no way. You cannot have this trained RN who is doing thirty patients alone with only one staff nurse.

P The problem is, Sister, yes, you will try but don't you think you're exposing yourself?

I That's why I'm saying you cannot expect one RN to run thirty patients, and these patients have got how many antibiotics?

--- END OF AUDIO ---

ANNEXURE G: Editor's declaration

DECLARATION

I, Franci Cronje, hereby declare that I have edited the dissertation 'REGISTERED NURSES' EXPERIENCES IN MANAGING PATIENTS DIAGNOSED WITH DEPRESSION IN A GENERAL MEDICAL WARD' by candidate MANDISA MPETSHU without changing original meaning or adding content to the script.

Signed

Dr Franci Cronje

Academic editor

Date: 18 October 2022

ANNEXURE H: Technical editor's declaration

DECLARATION

I, Rina Coetzer, hereby declare that I was responsible for the technical editing of the dissertation 'REGISTERED NURSES' EXPERIENCES IN MANAGING PATIENTS DIAGNOSED WITH DEPRESSION IN A GENERAL MEDICAL WARD' by candidate MANDISA MPETSHU, in accordance with the requirements of Tutorial Letter MNUALLL/301/2022 of the Department of Health Studies, Unisa.

Signed:

Mrs R Coetzer

Technical editor

Date: 26 November 2022

ANNEXURE I: Turnitin receipt

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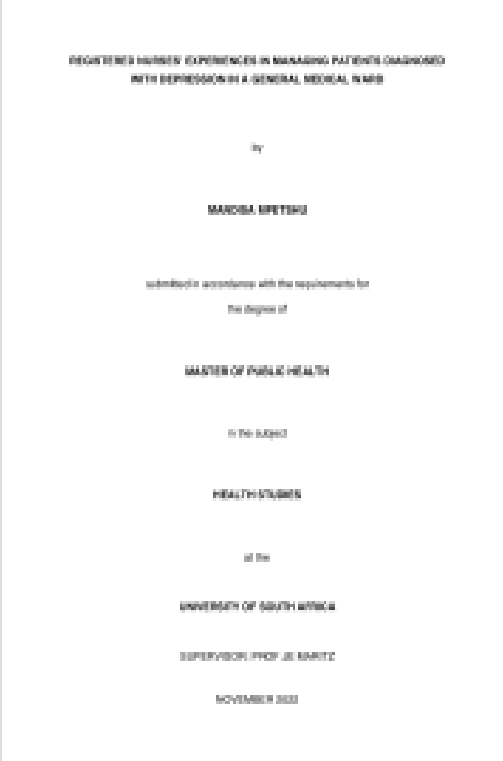

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by

MANDISA MPETSHU

submitted in accordance with the requirements for the degree of

MASTER OF PUBLIC HEALTH

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at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: PROF JE KRAFTZ

NOVEMBER 2022

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