

**THE INVESTIGATION OF PERCEPTIONS OF PROFESSIONAL NURSES
REGARDING CARE OF MENTAL HEALTH CARE USERS IN A GENERAL
HOSPITAL SETTING**

BY:

NONKANYISO YVONNE MANONA- NKANJENI

STUDENT NO. 8700664

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SUPERVISOR: N TSHOTSHO (Dr)
CO-SUPERVISOR: MRS NIN MAGADLA

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DECLARATION

I, NONKANYISO YVONNE MANONA- NKANJENI, declare that Perceptions of Professional Nurses Regarding Care of Mental Health Care Users in a General Hospital Setting is my own original work, and that I have not previously as a whole or in part submitted it for obtaining any qualification. Moreover, all the sources that I have used have been acknowledged.

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SIGNATURE

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DATE

ABSTRACT

This study sought to explore the perceptions of professional nurses regarding care of stabilised mental health care users in a general hospital setting. A qualitative, explanatory, descriptive and contextual design was used for the study. A non-probability, purposive sampling method was used to select 12 participants from the Cecilia Makiwane Hospital in Mdantsane. Data were collected through semi-structured interviews. The services of an independent interviewer were used to avoid any bias as interviews took place where the researcher is employed. The services of an editor were also used for language control (see Annexure H).

The researcher repeatedly listened to the tapes used for data collection until completely satisfied with the interpretation of verbatim data. The research study was conducted in an ethically reflective manner and trustworthiness was ensured at all times.

Four themes emerged from the analysis of the interviews: fear, stigma, myths and training. The researcher utilised the services of an independent coder who verified the identified major themes.

The findings revealed that participants were fearful due to lack of knowledge, experience and psychiatric nursing skills. Participants feared because they lack knowledge about psychiatric medication and because mental health care users may have relapse. The participants also attached a stigma to mental health care users, which resulted in poor communication between participants and the stabilised mental health care user; a negative attitude towards mental health care users; and non-acceptance. Participants believed in myths about mental illness; they regarded it as contagious; and perceived mental health care users as dangerous. The participants strongly recommended that training should be provided to improve their knowledge and skills to enable them to care for stabilised mental health care users in a general hospital setting. The following should be facilitated: in-service training; adoption of a positive attitude; dispersal of myths and fear; education about referral systems; and allocation of specialist psychiatric nurses to medical wards for referral purposes with regard to complicated cases.

DEDICATION

I dedicate this study to my late husband, my mother, my father, my sister and my brother who have always believed in me and have valued education. I would also like to express my gratitude to my loving niece, Zizipho, for her patience, love, support and understanding. I love you all so dearly.

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Contents

DECLARATION	i
ABSTRACT	ii
DEDICATION	iii
ACKNOWLEDGEMENTS	iv
CHAPTER 1	1
OVERVIEW OF THE STUDY	1
1.1 INTRODUCTION AND BACKGROUND	1
1.2 PROBLEM STATEMENT	2
1.3 RESEARCH QUESTION	3
1.4 PURPOSE	3
1.5 RESEARCH OBJECTIVES	3
1.6 SIGNIFICANCE OF THE STUDY	4
1.7 DEFINITION OF CONCEPTS	4
1.8 LITERATURE REVIEW	5
1.8.1 Biological factors that are involved in mental illness.....	7
1.8.2 Other biological factors that may be involved in the development of mental illness 7	
1.9 THE FRAMEWORK	8
Annexures and all other supporting information are added to the document.	8
1.11 CONCLUSION	8
RESEARCH METHODOLOGY	9
2.1 INTRODUCTION	9
2.2 RESEARCH METHOD	9
2.3 RESEARCH DESIGN	10
2.4 RESEARCH SETTING	11
2.5 POPULATION	11
2.6 SAMPLING	11
2.6.1 Sampling method	11
2.6.2 Sampling frame.....	12
2.6.3 Sample size.....	12
2.6.4 Inclusion criteria.....	13
2.6.5 Exclusion criteria	13
2.7 PILOT STUDY.....	13
2.8 DATA COLLECTION.....	14

2.9 DATA ANALYSIS.....	15
2.10 TRUSTWORTHINESS OF THE STUDY.....	17
2.10.1 Credibility (true-value)	17
2.10.2 Transferability (applicability).....	18
2.10.3 Dependability (Consistency).....	18
2.10.4 Confirmability (neutrality)	18
2.11 ETHICAL CONSIDERATIONS.....	19
2.11.1 Right to self-determination.....	19
2.11.2 Right to privacy.....	19
2.11.3 The right to anonymity and confidentiality.....	19
2.11.4 Right to fair treatment.....	20
2.11.5 Right to protection from discomfort and harm	20
2.12 Conclusion.....	20
CHAPTER 3.....	22
DATA ANALYSIS AND PRESENTATION OF RESULTS	22
3.1 INTRODUCTION	22
3.2 DEMOGRAPHIC DATA.....	22
3.3 THEMES THAT EMERGED	23
3.4 ANALYSIS AND PRESENTATION OF RESULTS.....	24
3.4.1 Fear	25
3.4.2. Stigma.....	30
3.4.3 Myths.....	33
3.4.4 Training	33
3.5 CONCLUSION	39
CHAPTER 4.....	41
DISCUSSION OF RESULTS, CONCLUSION, LIMITATIONS AND RECOMMENDATIONS	41
4.1 INTRODUCTION	41
4.2 DISCUSSION OF FINDINGS	41
4.2.1 Fear	42
4.2.1.2 Lack of knowledge of psychotropic medication.....	43
4.2.1.3 Mental health care users may relapse.....	43
4.2.2 Stigma	44
4.2.3 Myths.....	45
4.2.4 Training	46

4.3 LIMITATIONS.....	49
4.4 RECOMMENDED STRATEGIES TO IMPROVE CARE OF STABILISED MENTAL HEALTH CARE USERS IN A GENERAL HOSPITAL SETTING	49
4.4.1 Adequate knowledge, experience and psychic nursing skills	50
4.4.2 Knowledge about psychotropic medication.....	50
4.4.3 Prevention of mental health care user relapse in medical wards	50
4.4.4 Good communication.....	50
4.4.5 Not contagious.....	51
4.4.6 In-service training	51
4.4.7 Adopt a positive attitude	52
4.4.8 Dispel myths and fear	52
4.4.9 Referral system.....	52
4.4.10 Specialist psychiatric nurse in medical ward	52
4.5 IMPLICATIONS FOR FURTHER RESEARCH.....	52
4.6 APPLICATION OF FLORENCE NIGHTNGALE’S THEORY TO THIS STUDY	53
4.7 CONCLUSION	55
ANNEXURE A	63
Certificate of Approval from the University of Fort Hare Ethics Committee.....	63
ANNEXURE B.....	65
Letter of approval from the Eastern Cape Department of Health.....	65
ANNEXURE C	66
Letter of approval from the Non Interventional Hospital Review Board.....	66
ANNEXURE D	67
Letter of approval from Cecilia Makiwane Hospital Medical Superintendent.....	67
ANNEXURE E.....	68
Information given to participants.....	68
ANNEXURE F.....	69
WRITTEN INFORMED CONSENT FOR RESEARCH PROJECT	69
ANNEXURE G	70
Interview guide.....	70
ANNEXURE I.....	82
Letter from the editor	82

CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND

The study was conducted to determine the perceptions of general nurses working in a medical ward with regard to mental health care users (MHCUs) who were admitted for medical conditions in a general hospital setting of Cecilia Makiwane in the Buffalo City Metropolitan Municipality in the Eastern Cape Province.

The researcher, who is working in the psychiatric unit at the Cecilia Makiwane hospital, had noticed that general nurses who were allocated to the medical ward had an attitude towards caring for the stabilised MHCUs who were admitted to the medical ward for a medical condition. Such patients, having been discharged from a psychiatric unit or hospital, were regarded as having recovered enough to be maintained on psychotropic medication in the community. Like anyone else, they also, during their lifespan, suffer from other medical conditions. However, when these patients were admitted in the medical ward, nurses tended to focus on the controlled mental health problem at the expense of the current medical condition.

General nurses conduct nursing assessment on all patients admitted in the medical ward to identify their specific needs and the presenting problems. The nurses then formulate a nursing diagnosis and a nursing care plan, in consultation with the patient, based on the data obtained through assessment. Despite this process, the general nurses indiscriminately referred the stabilised psychiatric patients to the psychiatric unit for further management and care irrespective of their medical conditions. Such a situation exposes the patient to a risk of delayed effective management of the medical condition.

The professional nurses working in the medical wards seemed to lack knowledge that psychiatric conditions are treatable though not curable (Uys & Middleton 2007: 74-75). This was due to the fact that some of these professional nurses had not received psychiatric training. Such nurses seemed comfortable rendering care to those medically ill patients who did not have a history of mental illness.

The researcher also noted that some patients suffering from some medical conditions, like hypoglycaemia, diabetic coma, hypertension, epilepsy, septicaemia, and hyperpyrexia, sometimes presented with transient delirium, memory impairment, distorted thinking and behaviours, disorientation, agitation, and mental confusion. In some instances patients on confirmation of the diagnosis of a fatal illness like cancer and/or HIV and AIDs, presented with negative emotional reactions, like withdrawal and depression. Such patients were not diagnosed with psychosis and were immediately put on emergency treatment and, in the case of HIV and AIDS, were exposed to post-test counselling and given Anti-retroviral medications. Yet if the same occurred to a stabilised mental health care user (MHCU), the nurses just referred the patient to a psychiatric unit thus delaying the whole treatment process for the medical condition (Sadock & Sadock 2007: 367).

Such problems needed to be attended to in a medical ward. The expectation was that nurses in such wards would take a full history of the medical condition from the patient and relatives to determine the presenting complaint, the signs and symptoms and duration of the current illness. General nurses often expressed their fears about managing MHCUs, even though they were stabilised. They often requested psychiatric nurses to administer injections and to apply counselling skills in their wards when the patient was admitted.

It was not known why nurses in the general wards acted in the manner in which they did towards the stabilised mental health care users who were admitted for physical illnesses. The views of these nurses about such medically ill stabilised mental health care users were unknown; hence the researcher was interested in determining their perceptions and the rationale for their behaviour.

1.2 PROBLEM STATEMENT

A research problem involves an area of concern where there is a gap in the knowledge base needed for nursing practice. A problem statement comprises a single statement that presents the significance and background of a problem and identifies the gap in the knowledge base needed for practice (Burns, Grove & Gray 2009: 68 - 69). In Hofstee (2010: 85), a problem statement is described as the identification of the exact problem and discussion of reasons why it is a problem. The researcher, a practising psychiatric nurse at the Cecilia Makiwane hospital, noticed

that, when a stabilised mental health care user is admitted to the medical ward, the nurses seemed to be uncomfortable with caring for these users. The nurses often ignored the medical condition of the stabilised mental health care user and instead focused on the diagnosis of the stabilised psychiatric condition. The views of the general nurses about these patients were unknown and the reasons for their behaviour towards medically ill stabilised mental health care users were not known. It was not known why the general nurses did not render the care and management of the presenting medical problem, as warranted.

1.3 RESEARCH QUESTION

The research question that was formulated to investigate this state of affairs was: What are the perceptions for general nurses not willing to render nursing care to medically ill stabilised MHCUs who are admitted to medical wards?

1.4 PURPOSE

The research purpose is a clear concise statement of the specific goal or aim of the study that is generated from the research problem and usually indicates the type of study, (quantitative, qualitative, outcomes, or intervention) to be conducted and often includes the variables, population and setting for the study (Burns *et al.* 2009: 69). The purpose of this study was to determine and describe the perceptions of general nurses about medically ill stabilised MHCUs, their reasons for reluctance to render care to these patients when they are admitted to a medical ward in a general hospital setting as well as to improve care rendered by general health nurses to MHCUs.

1.5 RESEARCH OBJECTIVES

The objectives of this study were:

- To explore and describe the perceptions of general nurses about the stabilised MHCUs who are admitted to a medical ward for medical conditions.
- To determine the reasons why the nurses allocated in medical wards are unwilling to render care and treatment to medically ill stabilised mental health users.
- To make recommendations based on the results.

1.6 SIGNIFICANCE OF THE STUDY

The study has the potential to enable nurses working in medical wards within a general hospital to render holistic care to medically ill stabilised mental health care users.

1.7 DEFINITION OF CONCEPTS

A **General nurse** is an individual who, according to the Nursing Act (Act No. 3 of 2005) is qualified and competent to independently practise comprehensive nursing in a prescribed manner; One who is capable of assuming responsibility and accountability for his or her actions (South African Nursing Council, 2005a). In this study a general nurse is a professional nurse who obtained his/her diploma or a four year comprehensive training or degree in nursing, who is working in the medical ward.

Stabilised mental health care user, according to the Mental Health Care Act (Act No.17 of 2002), is a person who has been treated for a mental illness, has been discharged from a psychiatric hospital and is being maintained on treatment as an outpatient. In this study a stabilised MHCU is an individual who has recovered from mental illness, has been discharged and is being maintained on treatment as an outpatient in the community.

Perception is conscious awareness of elements in the environment by the mental processing of sensory stimuli, sometimes used in a broader sense to refer to the mental processes by which all kinds of data, intellectual, emotional and sensory are meaningfully organised (Sadock & Sadock 2007: 281). In this study perception refers to how the person gives meaning and interprets a situation or incident.

Medical ward is the unit in a general hospital where people suffering from medical conditions are admitted and grouped according to their special needs or diagnoses.

Health is defined by the World Health Organization (WHO) as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO 2001: 1) and health promotion is understood as 'actions that support people to adopt and maintain healthy lifestyles and which create supportive living conditions or environments for health' (WHO 2004: 5).

Mental health can be understood as: a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her own community (WHO 2001: 1).

Mental health care practitioners refers to a psychiatrist or registered medical practitioner or a nurse, occupational therapist, psychologist or a social worker who has been trained to provide prescribed mental health care, treatment and rehabilitation services (Mental Health Care Act No.17 of 2002). In this study, this refers to the doctors and nurses who are psychiatric-trained.

1.8 LITERATURE REVIEW

The literature review is an organised written presentation of what has been published on a topic by other scholars and includes a presentation of research conducted in a particular field of study (Burns *et al.*, 2009:93). The researcher conducted an extensive literature review in relation to the discussion of the results of this study, mainly after data collection and analysis as it is an acceptable practice in qualitative research. The preliminary literature review that was conducted was mainly for giving clarity to the problem being investigated, to identify the relevant theory, decide on a methodology for this study and to identify gaps in previous related research. The literature relevant to the topic was sourced from books, published research articles, scientific reports, WHO publications, legislation and other credible sources for scientific work (Burns *et al.*, 2009).

In McGrath & Jarrett (2007: 4) the perceptions of professional nurses regarding care of MHCUs in medical wards are related to fear, ignorance and lack of experience in dealing with mental illness. Cooper (2010: 199), states that mental illness involves a lack of will power, and is a stress related illness rather than a medical illness and as such nurses reported that it is risky to work in the unit with known mental health care users because they may become aggressive and require one to be very tactful.

About 450 million people suffer from mental disorders, according to estimates given in the World Health Organization (WHO) World Health Report of 2001 (WHO, 2001). One person in every four will be affected by a mental disorder at some stage of their life. Unipolar depression, self-inflicted injuries and alcohol use disorders are among the top 20 leading causes for the disease burden among all ages. Six

neuropsychiatric conditions rank among the top 20 causes for the disease burden in the 15 to 44 year age group. It is estimated that by the year 2020, depression will become the second leading cause for disease burden (Murray & Lopez, 1996). Mental illness affects the functioning of the individual, resulting not only in enormous emotional suffering and a diminished quality of life, but also alienation, stigma and discrimination. To reduce the burden of mental disorders, it is essential that greater attention be given to prevention and to promotion of mental health at the level of policy formulation, legislation, decision-making, resources allocation and the overall health care system.

The literature makes reference to the relationship that exists between physical illness and mental disorders. Such a relationship is more pronounced in chronic, fatal physical conditions (Meade & Sikkema 2005:25). Some of the patients attending or presenting at the hospital setting have a mental or neurological disorder (Chisholm, Flisher, Lund, Patal & Saxema 2002:370). There is a relationship between mental and chronic physical disorders. If one is suffering from severe mental illness, citing psychopathology and the related risk, one may be at the risk of HIV infection, as some psychopathologies lead to sufferers losing contact with reality, having poor insight and poor judgement, as well as limited decision-making and problem-solving capacities (Meade & Sikkema 2005:25). During a relapse, MHCUs can be infected easily as they often practise unprotected sex with multiple partners. The goal of all medical care is to achieve health. The Constitution of the World Health Organization defines health as the state of complete well being physically, mentally and socially (WHO 2001). For the affected individual with existing disorders, this entails the restoration of physical, mental and social well-being, using prescribed treatment, care and rehabilitation.

Medically unexplained symptoms are commonly encountered in medical practice. People with medically unexplained symptoms have been shown to have higher rates of psychiatric disorders (Govender & Cloete 2011: 45). These people have the following: somatic syndrome, irritable bowel syndrome, non-ulcer dyspepsia, fibromyalgia and chronic fatigue syndrome.

1.8.1 Biological factors that are involved in mental illness

Some mental illnesses have been linked to an abnormal balance of special chemicals in the brain called neurotransmitters. Neurotransmitters help nerve cells in the brain communicate with each other. If these chemicals are out of balance or are not working properly, messages may not make it through the brain correctly, leading to symptoms of mental illness. In addition; defects or injury to certain areas of the brain have also been linked to some mental conditions.

1.8.2 Other biological factors that may be involved in the development of mental illness

Other biological factors that may be involved in the development of mental illness include:

Genetics: Many mental illnesses run in families, suggesting that people who have a family member with a mental illness are more likely to develop one too. Experts believe many mental illnesses are linked to abnormalities in many genes. Mental illness itself occurs from the interaction of multiple genes and other factors, such as stress, abuse, or a traumatic event- which can influence, or trigger, an illness in a person who has an inherited susceptibility to it (Sadock & Sadock 2007:123).

Infections: Certain infections have been linked to brain damage and the development of mental illness or the worsening of its symptoms. For example, a condition known as paediatric autoimmune neuropsychiatric disorder (PANDA) associated with streptococcus bacteria has been linked to the development of obsessive compulsive disorder and other mental illnesses in children.

Brain defects or injury: Defects in or injury to certain areas of the brain has also been linked to some mental illnesses (Sadock & Sadock 2007:390).

Prenatal damage: Some evidence suggests that a disruption of early foetal brain development or trauma that occurs at the time of birth for example, loss of oxygen to the brain – could be a factor in the development of certain conditions, such as autism (Sadock & Sadock 2007:361).

Substance abuse: Long- term substance abuse, in particular, has been linked to anxiety, depression, paranoia and foetal alcohol syndrome (Sadock & Sadock 2007:380).

Other factors: Poor nutrition and exposure to toxins, such as lead, may play a role in the development of mental illnesses (Sadock & Sadock 2007:366).

1.9 THE FRAMEWORK

A framework is an abstract, logical structure of meaning. It guides the development of the study and enables the researcher to link the findings to the body of knowledge used in nursing (Burns *et al.*, 2009: 126). Brink (2006: 24) states that the framework of a research study helps the researcher to organise the study and provides a context in which he/she examines a problem and gathers and analyses data. There are two types of frameworks: the theoretical and the conceptual framework .This study was guided by Nightingale’s environmental theory of nursing (Kneisl & Trigoboff 2008:280). According to this theory, nursing practice is regarded as holistic. Nursing is the caring of a patient in totality physically, psychologically and socially. The three components need to be viewed as interrelated rather than as separated. A further description and explanation of this theory with regard to this study will be presented in the chapter dealing with the literature review and will further form a basis for the discussion of the results of this study.

1.10 RESEARCH METHODS

The research methods will be discussed in Chapter 2. This discussion will comprise: study design; study setting; study population; sampling; inclusion criteria; exclusion criteria; trustworthiness; pilot study; data collection; data analysis; and ethical consideration.

Annexures and all other supporting information are added to the document.

1.11 CONCLUSION

In this chapter, the background, problem statement and research objectives relevant to the study, were described. The next chapter will present the research methodology.

CHAPTER 2

RESEARCH METHODOLOGY

2.1 INTRODUCTION

This chapter outlines the research methodology applied during this study. The methodology chapter describes the research approach, the design, methods that the researcher used to obtain data, how the research was done as well as the instruments that were used.

It is also focused on the pilot study, data collection and data analysis processes, sampling, ethical considerations and trustworthiness of the study.

2.2 RESEARCH METHOD

Polit & Beck (2008: 731) define a research method as a technique used to structure a study, to gather and analyse information in a systematic fashion.

In this study, the researcher used the qualitative, exploratory, descriptive and contextual research approach, because the study was focused on the perceptions of professional nurses. The researcher applied the characteristics of the qualitative approach and identified an approach that supported the phenomenon that was studied (Speziale & Carpenter 2007: 21). During the study, the researcher's perceptions, reflection and interpretations influence the data collected from the study participants. Phenomenological research is an effective methodology for discovering the meaning of a complex perception as it is lived by a person such as the live perception of chronic illness (Burns, Groove & Gray 2009: 21). This type of research was utilised in this study.

This design was the choice for the study because it reflected the perceptions of professional nurses regarding care for stabilised mental health care users in a general hospital setting.

The researcher in this particular study chose a descriptive study, because she intended to generate an in-depth description of perceptions of professional nurses regarding care for stabilized MHCUs in a general hospital setting so as to understand how nurses manage these MHCUs.

According to Burns *et al.* (2009: 8), qualitative researchers are more interested in understanding complex phenomena than in determining cause-and-effect relationships.

This approach was found suitable for this study because the aim of the researcher was to examine the whole rather than parts as indicated in Burns *et al.* (2009: 8) as well as the belief in multiple realities as discussed in Speziale & Carpenter (2007: 21) under characteristics of qualitative research.

The researcher used the qualitative, exploratory, descriptive and contextual approach to study human phenomena and describe human perceptions, which were not easy to quantify. The researcher hoped that the findings of the researcher would lead to a choice of method.

2.3 RESEARCH DESIGN

According to Burns *et al.* (2009: 218), the research design is a blueprint for conducting the study that maximises control over factors that could interfere with the validity of the findings. These authors stated that the research design guides the researcher in planning and implementing the study in a way that is most likely to achieve the intended goals. Polit & Beck (2008: 766) define the research design as the overall plan for addressing a research question, including specifications for enhancing the study's integrity.

Babbie & Mouton (2009a: 74) describe a research design as a plan or blueprint of how the researcher plans to conduct the research and this will be clear during the study.

In this study the researcher used a qualitative approach which gave the participants an opportunity to express their views or concerns due to perceptions regarding the care of stabilised MHCUs in medical wards. The participants were allowed to express themselves in a manner which revealed the real situation. The participants were able to express lived experiences.

Explorative design was used in this study, as the researcher wanted to get information on how the professional nurses perceived care of stabilised MHCUs in medical wards. The researcher conducted interviews to explore and describe the lived perceptions of nurses.

The descriptive study design was used to gain more information, identify problems with current practice, justify current practice, make judgements or determine what others in similar situations are doing (Burns & Grove 2005: 232). By making use of descriptive research, the researcher used interviews to gain information about the professional nurses' perceptions in an effort to obtain complete and accurate information for this study. Burns and Grove further explain the purpose of descriptive research as to provide a picture of a situation as it naturally occurs.

Descriptive design is defined as a non-experimental design to be used when the researcher wants to describe variable interests (Botma, Greeff, Mulaudzi & Wright, 2010: 110). The advantages of descriptive design are that the research process is relatively inexpensive and takes less time to conduct.

Contextual research was appropriate for this study because the aim of the study was to describe and understand the study within the natural context in which the phenomenon of interest occurs.

2.4 RESEARCH SETTING

The setting for this study was presented in Chapter 1. Permission to conduct the research in this setting was obtained from the superintendent of the general hospital (see Annexure D).

2.5 POPULATION

The target population for this study were professional nurses, who were psychiatric-trained and those who had not undergone psychiatric training, working in the medical wards in the Cecilia Makiwane Hospital at the time of data collection. The criteria for inclusion and exclusion are later discussed in this chapter.

2.6 SAMPLING

2.6.1 Sampling method

In this study a purposive, non-probability sampling method was used. Purposive sampling is a sample based on own judgement and the purpose of the study is regarded by Babbie & Mounton (2009b: 166) as appropriate for the researcher to select.

In non-probability sampling, not every member of the population has an opportunity for selection in the sample (Burns & Grove, 2005: 40). Although these authors indicated that non-probability sampling methods increase the possibility of obtaining samples that are not representatives of their target population, the purposive non-probability sampling was however the method of choice for this study, because the researcher wished to gain insight and an in-depth understanding of how the professional nurses perceived the care of stabilised MHCUs in medical wards. The researcher targeted the participants that she knew would be those that provide her with the information she required.

2.6.2 Sampling frame

The sampling frame is a comprehensive list of the sampling elements in the target population (Brink 2006: 124). The researcher prepared a sampling frame by listing all members of the accessible population. This was a time consuming task, and the researcher took care to delineate the population accurately. Babbie & Mouton (2009a: 174) refer to a sampling frame as the actual list of sampling units from which the sample is selected.

In this study the sampling frame was a list of all professional nurses with less than five years' experience working in the medical wards whose ages were between 25 and 35 simply because they are still eager to learn and gain more knowledge of nursing. The sample also included professional nurses who are psychiatric-trained but lacked the knowledge and skills to care for MHCUs because they were not placed in a psychiatric ward after training. This list was elicited with the assistance of the nurse-managers in the medical wards through the ward allocation list and records obtained from the Human Resource department of the hospital.

2.6.3 Sample size

According to Kumar (2005: 65), the sample size concerns the number of elements from whom the required information is obtained. Burns *et al.* (2009: 361) stated that the sample size is determined by the purpose of the study as well as the in-depth, rich information needed to gain insight into the study. These authors further state that the focus is on the quality of information obtained from the participants rather than the size of the sample.

Therefore, the sample size was determined by the generated data and information obtained from the professional nurses. Burns *et al.* (2009: 361) also indicate that the number of the participants is adequate once saturation of information is achieved, which means that additional participants do not contribute any new information to the study.

The researcher interviewed 12 participants at which point the actual data was saturated. Saturation of data occurs when additional sampling provides no new information, only redundancy of previously collected data (Burns & Grove 2005: 358).

2.6.4 Inclusion criteria

- General nurses working in the medical wards that had admitted or rendered nursing care to medically ill stabilised MHCUs during the preceding twelve (12) months could be included in the research.

2.6.5 Exclusion criteria

- General nurses working in medical wards who had never admitted or rendered nursing care to medically ill stabilised MHCUs during the preceding twelve (12) months were excluded from the research.

2.7 PILOT STUDY

A pilot study, according to De Vos, Strydom, Fouch & Delport (2005: 206), is a small study conducted prior to a larger research project to determine whether the methodology, sampling, instruments and analysis are adequate and appropriate. The pilot study is done to test the validity of the interviewer's schedule, as well as to sharpen the practice and interviewing skills.

According to Brink (2003: 213), a pilot study is a small-scale version of the major study conducted prior to the main study on a limited number of participants from the population at hand. Brink further stated that a pilot study is viewed as part of the planning phase during which information could be obtained for improving the project. The pilot study allowed the researcher to identify problems early by obtaining information for improving the object, making adjustments to the instruments, or re-assessing the feasibility of the study.

Burns *et al.* (2009: 44) define a pilot study as a smaller version of a proposed study. The researcher did a pilot study to determine the feasibility of the study and to identify possible problems early, in order to refine the research.

A pilot study was conducted in June 2014 to test the feasibility of the study. This pilot study was conducted with three participants from the medical wards who met the criteria but were not part of the study. The researcher followed all the steps of the research process up to the findings. By doing so, the researcher had the opportunity to detect possible flaws in the interview guide. The pilot study assisted the researcher in mastering interviewing skills.

2.8 DATA COLLECTION

Data collection is the precise, systematic gathering of information relevant to the research purpose or the specific objectives, questions or hypothesis of the study (Burns *et al.* 2009:695). According to Polit & Beck (2008:716) data collection is the gathering of information to address a research problem which was what the researcher did during this study.

A variety of strategies were used to generate qualitative research data. These included interviews, observations, narrative and focus groups (Speziale & Carpenter 2007:35).

The researcher conducted individual interviews and engaged in reflection to collect needed data. Interviews were unstructured and were conducted in a suitable environment and they were audio taped.

A suitable environment for interviews for this study was ensured for privacy, freedom from noise, comfort and convenience for the participants. Interviews lasted for approximately forty-five (45) minutes each. The researcher collected data from participants in a face-to-face manner at work, the familiar venue of the participants, thus encouraging cooperation. Eye contact was maintained and was done where necessary. The use of eye contact was important because it was where the researcher picked up the non- verbal cues. Communication skills were used; the researcher listened attentively and kept on nodding to confirm attentive listening. Probing was used to encourage participants to elaborate (Brink 2006:152). Open-ended questions were posed to find out about the values, preferences, interests,

tasks and perceptions of the participants. During interviewing the researcher recorded and made notes of all information, the interviewer having obtained permission from the participants in advance.

Examples of questions which were asked were framed as follows: What are the perceptions for general nurses not willing to render nursing care to medically ill stabilised mental health care users who are admitted to medical wards? What are your views about medically ill stabilised MHCUs who are admitted to a medical ward? What would you recommend as a strategy to render holistic nursing care to these patients in a medical ward? (Refer to Annexure G). Data collection continued until data saturation was reached.

Towards the end of the interview, the researcher asked the participants for any other input with regard to the care of stabilised MHCUs in the medical ward. The data collected were transcribed and analysed. An experienced supervisor in qualitative research assisted with coding and identifying themes.

2.9 DATA ANALYSIS

Data analysis entails categorising; ordering; manipulating; and summarising the data and describing them in meaningful term (Brink 2006:170). Polit & Beck (2008:716) explain data analysis as the systemic organisation and synthesis of research data. In preparation for research data analysis the researcher counted the number of all participants who were involved with the research to ensure that no information provided by the participants was omitted.

Data analysis was conducted concurrently with data collection and it began at the start of the data collection phase. The audio-taped interviews were listened to repeatedly to compare them with the transcriptions. Interviews were transcribed verbatim. All responses were read over and over to gain a sense of their meaning. During this process, key phrases were marked and sentences and feelings expressed by the respondents were noted. After proofing the transcripts, information was sorted into categories to form a story (Creswell, Hiebert & Frances 1994: 153). The data analysis process was guided by Tesch's steps (1990).

Creswell *et al.* (1994:155) outline the steps as follows:

Getting a sense of the whole by reading through all the transcriptions carefully and jotting down ideas.

Picking the most interesting interview and considering its content.

Categorizing topics as major, unique and “leftovers” abbreviating the topics as codes and writing the codes next to the appropriate segments of the text, and then trying out this preliminary organizing scheme to see whether new categories and codes emerge.

Finding the most descriptive wording for the topics and turning them into categories and grouping topics that relate to each other in order to reduce the total list of categories.

Make a final decision on the abbreviation of each category and placing codes in alphabetic manner.

Assembling the data belonging to each category in one place and perform a preliminary analysis.

Field notes were expanded by transforming shorthand into narrative and elaborating on non-verbal observations made during the interviews. All expanded notes were then transcribed and typed into a computer for analysis. Analysis included careful checking of all data collected as well as attentive listening to and analysis of the audiotape. The transcript was read through thoroughly with the aim of interpreting the responses of the 12 participants.

The qualitative feedback of the participants was interpreted by identifying themes in response to each question asked by the researcher. The researcher was guided by the supervisor in this process, in order to enhance the trustworthiness of the themes identified.

The transcriptions, together with the field notes were sent to “an independent coder” (Creswell *et al.*1994:158) for analysis. The coding process resulted in the emergence of themes. These were refined during the consensus discussion with the co-coder. The researcher and the co-coder agreed on the categories, subcategories and the themes identified in the transcriptions. The transcriptions were taken to the supervisor, an expert in qualitative research, who assisted with coding of the transcripts. The written copies were coded. Coding is used to organise data collected in interviews.

Memos were made about the context of and in the phenomenon under study. Selected themes were verified through reflection on the data and through discussions with other researchers or experts in the field. The information was categorised. The researcher checked the reliability of the coding with the help of an independent coder. The researcher and the co-coder used a work protocol to ensure the use of the same steps in analysing the data thereby adding to the trustworthiness of the study.

2.10 TRUSTWORTHINESS OF THE STUDY

Speziale & Carpenter (2007: 49) state that the goal of rigour in qualitative research is to study participants' perceptions accurately. The same authors identified the following measures to demonstrate the trustworthiness of the research, credibility (true-value), transferability (applicability), dependability (consistency) and confirmability (neutrality).

2.10.1 Credibility (true-value)

Speziale & Carpenter (2007: 49) state that credibility includes activities that increase the probability that credible things will be produced. Babbie & Mouton (2009a: 277) indicate that credibility is achieved by prolonged engagement, persistent observation, triangulation, referential adequacy and peer debriefing as well as member checks.

In this study, findings were mutually established between the researcher and the participants. The researcher ensured that the truth of perceptions of professional nurses regarding care of stabilised MHCUs in a general hospital setting was uncovered. This was achieved through being immersed in the setting for a prolonged period, conducting interviews, observing and taking notes with each participant.

Accuracy was maintained throughout the study by making use of member checks and allowing the participants of the information to check both the data and the interpretation (Babbie & Mouton 2009b: 277). In-depth information pertaining to the study was given to the participants to enable them to answer the questions asked during the interview appropriately. The researcher also consulted colleagues who have experience in qualitative research, as well as the supervisor, to discuss the process and results of the study from time to time.

2.10.2 Transferability (applicability)

Speziale & Carpenter (2007: 49) state that transferability refers to the probability that the findings have meaning for others in the same situation. The researcher enhanced the transferability of the study by safeguarding all data transcripts, analysed data records and cassette discussion records. The researcher provided an in-depth discussion and interpretation of data and by using purposive sampling.

2.10.3 Dependability (Consistency)

According to Brink (2006: 119), dependability is a further criterion listed by Lincoln and Guba (1985) for establishing the trustworthiness of the study. Dependability refers to the extent to which similar findings would be obtained through repeated research (Babbie & Mouton 2009a: 277). Speziale & Carpenter (2007: 49) state that dependability is a criterion that is met once researchers have demonstrated the credibility of the findings.

To adhere to the dependability requirement, the researcher conducted a pilot study and interviewed several participants until saturation of data was reached, when the same themes started reappearing in the data.

2.10.4 Confirmability (neutrality)

Speziale & Carpenter (2007: 49) explain confirmability as the way the researcher documents findings over time to allow other individuals to follow. Babbie & Mouton (2009a: 277) indicate that confirmability is the extent to which the findings are the outcomes of the research and not the biases of the researcher. According to Brink (2006:119) confirmability guarantees that the findings, conclusions and recommendations are supported by the data and that there is internal agreement between the investigator's interpretation and the actual evidence. This is also accomplished by incorporating an audit procedure. The researcher maintained the confirmability of this study by taking notes throughout the research process, ensuring that the data were accurately interpreted, and reflected the data obtained from the participants.

2.11 ETHICAL CONSIDERATIONS

Ethics of nursing research is defined as those aspects of the project that impinge upon the moral and social aspects of society (Landy & Comte 2007:190). The researcher has an ethical responsibility to recognise and protect the rights of human research subjects (Burns *et al.* 2009:184). The researcher undertook the actions essential for conducting research ethically, namely protecting the rights of the participants; balancing the rights and the risks in this study; obtaining informed consent from the participants; ensuring the right to self-determination; the right to privacy; the right to anonymity and confidentiality; the right to fair treatment; and the right to protection from discomfort and harm; and also submitted the proposal for institutional review and approval (see Annexures A, B and C).

2.11.1 Right to self-determination

The right to self-determination is based on the ethical principle of respect for persons (Burns & Grove 2005:181). People should be treated as autonomous agents, who have freedom to conduct their lives as they choose without external controls. Participants were informed about the proposed study. They were allowed to voluntarily choose to participate or not. They were told that they could decide to withdraw without a penalty at any time.

2.11.2 Right to privacy

Privacy is the right an individual has to determine the time, extent, and general circumstances under which personal information will be shared with or withheld from others (Burns & Grove 2005:181). The data were gathered from participants after they had been informed. The names of the participants were not printed anywhere in the study. The individuals also had the right to access their records and to prevent access by others to these records (Muller 2008:67).

2.11.3 The right to anonymity and confidentiality

Participants had the right to anonymity and the right to assume that the data collected would be kept confidential. The researcher desired to know the identity of the participants but promised that their identity would be kept anonymous with regard to others. The researcher received authorization from the potential participants to use their health information.

Confidentiality concerns the researcher's management of private information shared by a participant that must not be shared with others without the authorisation of the participant (Burns & Grove 2005:188). Participants shared personal information to the extent they wished and were entitled to have secrets. One chooses with whom to share personal information. People who accepted information in confidence had an obligation to maintain confidentiality. The anonymity of participants was protected by giving each participant a code.

2.11.4 Right to fair treatment

The right to fair treatment is based on the ethical principle of justice (Burns & Grove 2005:189). This principle holds that each person should be treated fairly and should receive what he or she is owed. Participants were selected for reasons directly related to the problem being studied. Researcher and subjects had a specific agreement about what a participant's participation involved and what the role of the researcher was. Treating participants fairly often facilitated the data collection process and decreased participant withdrawal from a study.

2.11.5 Right to protection from discomfort and harm

The right to protection from discomfort and harm is based on the ethical principle of beneficence, which holds that one should do good and, above all, do no harm (Burns & Grove 2005:190-191). According to this principle, members of society should take an active role in preventing discomfort and harm and promoting good in the world around them. Discomfort and harm can be physiological, social, emotional and economic in nature (Muller 2008:67). The following are the categories based on levels of discomfort and harm: no anticipated effects; temporary discomfort; unusual levels of temporary discomfort; risk of permanent damage; and certainty of permanent damage (Muller 2008:67). The interviews were conducted in a private room, thus ensuring safety and comfort of the participant.

2.12 Conclusion

This chapter presented the research methodology. A qualitative research method was conducted using the phenomenological approach. Basic interviewing and, participant observations were used as an instrument in this study. The target population for this study comprised professional nurses working in medical wards in a general hospital. A non-probability sampling method was used. Data was collected

and analysed. The research was piloted by using participants that were not part of the actual research, but from the same population. The researcher also considered trustworthiness of the study as well as ethical principles.

CHAPTER 3

DATA ANALYSIS AND PRESENTATION OF RESULTS

3.1 INTRODUCTION

This chapter presents the findings from the research, obtained through content analysis of the data. The demographic data of the participants and the themes that emerged are included.

Tesch's eight steps were followed for data analysis of results, as discussed in Chapter 2. The analysis of results in this chapter was guided by the responses to the three objectives and aims of the study, which were: (1) to explore and describe the perceptions of general nurses about the stabilised mental health care users who are admitted to a medical ward for medical conditions; (2) to determine the reasons why the nurses allocated in medical wards are unwilling to render care and treatment to medically ill stabilised mental health care users; and (3) to make recommendations based on the results.

The themes, categories and sub-categories presented in the chapter emerged from the phrases which are the "units of meaning" that were obtained from statements in the descriptions of the perceptions of the participants.

The chapter therefore focuses on identified themes that were derived from the data that were collected. Relevant quotations from the participants as well as demographic data are included in this chapter.

Participants were given explanations of all aspects of research process and all agreed to participate and voluntarily signed the informed consent (see Annexures E and F).

All interviews were audiotaped and transcribed verbatim after conducting the interviews to make sure that all data which is needed is captured.

3.2 DEMOGRAPHIC DATA

Saturation was reached after interviewing twelve (12) participants. These were female and male participants who worked in medical wards at the Cecilia Makiwane Hospital. Their ages ranged from 25 years to 35 years. The researcher conducted

several interviews with different professional nurses allocated to different medical wards, the two (2) female wards being ward one (1) and ward seven (7) and the two (2) male wards being ward eight (8) and ward fourteen (14)

3.3 THEMES THAT EMERGED

Four main themes emerged from data analysis and these were as follows: (1) fear; (2) stigma; (3) myth; and (4) training.

The categories and subcategories which related to the identified themes were used to develop the discussion that enabled the researcher to present findings which emanated from perceptions of professional nurses regarding the care of mental health care users in a general hospital setting.

The researcher created a template to illustrate themes, categories and subcategories. This template is illustrated in Table 3.1.

TABLE 3.1

Themes, categories and subcategories regarding perceptions of professional nurses on care of stabilised mental health care users in a general hospital setting.

MAIN THEMES	CATEGORIES	SUB-CATEGORIES
1. Fear	1.1 Lack of knowledge, experience and psychiatric nursing skills. 1.2 Lack of knowledge about psychotropic medication 1.3 Mental health care user might relapse	<ul style="list-style-type: none"> • Inability to identify signs of relapse • Lack of knowledge about different types of psychotropic drugs, dosage, side effects and management thereof • Physical illness as a trigger for mental illness • Inability to intervene when user has relapsed
2. Stigma	2.1 Poor communication 2.2 Negative attitude towards mental health care user 2.3 Non acceptance	<ul style="list-style-type: none"> • No response or minimal verbal communication • Residual mental illness • Poor trust • Possibility of visual and auditory hallucinations • Destructive
3. Myths	3.1 Contagious 3.2 MHCUs are perceived as dangerous	Acquisition of mental illness by nursing the MHCU
4. Training	4.1 In-service training 4.2 Adopt a positive attitude 4.3 Dispel myths and fear 4.4 Referral systems 4.5 Specialist psychiatric nurse in medical ward	<ul style="list-style-type: none"> • Provision of training to acquire skills and competence & about psychotropic medication • Climate meeting • Part-time course • Awareness day/campaigns • Consult with the specialist psychiatric nurse for guidance and advice

3.4 ANALYSIS AND PRESENTATION OF RESULTS

The main themes, categories and subcategories are analysed and presented in this chapter. The following discussion of results is supported by direct quotes from the

participants, as well as the literature control. Although the professional nurses had different perceptions, they reported the same commonalities which formed the main themes for the study. These are discussed in detail.

3.4.1 Fear

This is one of the main themes that were identified on data analysis. Sadock & Sadock (2007:277) describe fear as an unpleasant emotional state consisting of psychological changes in response to a realistic threat or danger.

According to this study fear represents the state where the professional nurses working in medical wards are afraid to care for stabilised mental health care users who are admitted to a general hospital with a medical condition. The researcher, a practising psychiatric nurse, has heard comments from nurses who are afraid of caring for stabilised MHCUs who are admitted to their wards. Nurses confided that they do not trust MHCUs and that it is risky to look after them. This makes them unwilling to care for MHCUs. Participants indicated that, the physical layout and the fittings in the medical wards are designed for medical care and not for mental health care needs. Exits in medical units are unsecured as compared with the psychiatric department. It becomes a problem when the MHCU is admitted to the medical ward because the MHCU sometimes becomes restless and exits the unit unattended. These MHCUs are found wandering within the general hospital premises, where they could be exposed to danger. The MHCUs are at high risk of danger within the hospital premises. Dangerous objects, like scissors, are within reach of MHCUs and are not locked away. The doctors' round trolleys are within reach unlike in the mental units where the trolley for doctors' rounds is in a separate room where the psychiatrist and nurses do consultation together.

When unit rounds are conducted in the mental/psychiatric department, the whole multi-disciplinary team, which consists of a psychiatrist, medical doctor, psychiatric nurse, social worker, psychologist and occupation therapist, is involved. The condition of the MHCU is discussed and it is known who is going to do what at the end of the conference. Even if MHCUs are stabilised, their mental status is unpredictable because they are easily irritated.

These nurses explained that stabilised MHCUs are sometimes unpredictable; they like to isolate themselves, like to sleep and do their own things the way they like at

their own time. Other stabilised MHCUs were often found talking to themselves, were restless and at times laughed inappropriately. The nurses also feared that MHCUs in medical wards might harm and cause fear in other medical patients who were bed ridden around them. This theme is supported by the identified categories and subcategories which are discussed below.

Fear is related to lack of knowledge, experience and psychiatric nursing skills, lack of knowledge about psychotropic medication as well as the fact that mental health care users might relapse. Lack of knowledge, experience and psychiatric nursing skills is characterised by inability to identify signs of relapse. Lack of knowledge about psychotropic medication is characterised by lack of knowledge about different types of psychotropic drugs, dosages, side effects and management thereof. Mental health care users might relapse because of physical illness which may trigger mental illness.

3.4.1.1 Lack of knowledge, experience and psychiatric nursing skills

In this study, the researcher explored the perceptions of general nurses towards stabilised MHCUs in general wards. The major factors that nurses identified as affecting their ability to care for MHCUs were a lack of time to care for these MHCUs and a lack of skills, knowledge and experience with MHCUs (Ndetei, Khasakhala, Mutiso & Mbwanyo 2011:233).

Participants had a limited knowledge, experience and nursing skills with regard to caring for stabilised mental health care users with a medical condition who are admitted to a medical ward. The participants had limited experience and this made them fearful and threatened.

Other participants felt that their experience of caring for stabilised mental health care users in a medical ward was predominantly negative. The participants felt inadequate and were anxious; therefore they ended up avoiding these mental health care users. The rights of mental health care users were ignored and their needs were largely unmet. The participants did not feel comfortable about caring for the mental health care users despite the fact that they were the patient's advocate for their care. The participants related this attitude of feeling threatened to a perceived lack of control versus their sense of responsibility to maintain the health and safety of their patients in care.

These participants expressed the feeling of being unable to identify signs of relapse. Relapse is the state of people who tend to progress toward change, but slip back to familiar patterns of previous behaviours. When health-related behaviours are involved, this slipping back is referred to as relapse (Kneisl & Trigoboff 2008:55). The participants did have a fear of being harmed by relapsed users and also felt that other patients in their care were not safe. The participants also felt vulnerable professionally, legally and ethically for their action or inaction to avoid harm.

“I feel frightened because these stabilised mental health care users are unpredictable and they are potentially dangerous. If they can relapse they will harm bedridden and helpless patients and I’ll be responsible for that.”

“Not knowing the cause of patient to behave strangely makes me feels uncomfortable. “Struggling to notify the doctor and sometimes the doctor takes time to respond to your call is frustrating”

Some participants indicated that they were motivated as they saw good results and received positive feedback from their care. Participants were supported by their supervisors and colleagues from the mental health department because they lacked skills.

Nurses need to allocate time to share views with MHCUs every day to find out more about the condition, and whether the MHCU is improving or not. All skills need to be applied by nurses caring for the MHCU, for instance, listening and communication skills. These skills may help with diagnosis and treatment of the MHCUs. When probing stabilised MHCUs and the nurses do not get information which is needed, the question must be rephrased to get what is needed (Arnold & Mitchell 2008: 31 – 32). A low level of awareness of mental illness among general hospital staff, due to lack of knowledge, may lead to an unmanaged mental disorder which in turn would adversely affect the outcome of the physical condition (Ndetei *et al.* 2011: 234). In Lethoba, Netswera & Rankhumise (2006: 4) general nurses are reported as stating that, when they assessed the MHCUs, they could not handle them and they did not want anything to do with them and do not understand enough about them. In Ndeteri *et al.* (2011:229), some general nurses believed that mental illness was a problem for relatives and that it was not necessary for the MHCU to be admitted in a general ward. Others believed that mental illnesses are best managed by witchdoctors. The purpose of this study was to improve care rendered by general health nurses to MHCUs.

Once the MHCU is admitted to the general ward, it is important to notify the psychiatrist so that treatment may be prescribed for the MHCU. The education about compliance for both psychiatric and medical treatment needs to be done to prevent default of treatment by MHCUs. Compliance helps the stabilized MHCU not to relapse while they are admitted to medical ward (Reed & Fitzgerald 2005:252).

Education in mental health has been considered an essential part of nurse education (Wynaden, McGowan & Downie 2000:136). The education provided by the mental health care team proved beneficial because the participants reported greater understanding, confidence and control and a reduced perception of danger. Nurses working in medical wards need more practical and emotional support in caring for stabilised mental health care users because they are fearful.

In-service educational programmes for staff working in both psychiatric and medical departments need to be offered to equip those who lack knowledge, skills and experience. These programmes will help to close the gap between the level of education between psychiatric and medical staff (Reed & Fitzgerald 2005:252).

3.4.1.2 Lack of knowledge about psychotropic medication

Medications used to treat psychiatric disorders are referred to as psychotropic drugs (Sadock & Sadock 2007:976). These drugs are commonly described by their major clinical application, for example, antidepressants, antipsychotics, mood stabilisers, anxiolytics, hypnotics, cognitive enhancers and stimulants. Some participants had a lack of knowledge of different types of psychotropic drugs, dose, side effects and management thereof. Mental health care users admitted to medical wards with medical conditions take their prescribed psychiatric treatment together with current treatment. Participants do not know generic names of psychotropic medications. They were complaining about unfamiliarity with these drugs. They stated that they did not know the side effects caused by these drugs.

Side effects of medication are defined as unintended physical effects of medication (Kneisl & Trigoboff 2008:851). Side effects are sometimes called adverse effects. The participants ignored mental health care users who reported the following side effects, twisting of the neck or pulling of the neck down into the shoulders, tremors, protruding tongue, feeling of irritability and many others. They continued

administering the prescribed treatment because they were unaware that they needed to notify the doctor and review the prescribed treatment.

“I just ignore the mental health care users when communicating trying to report about funny symptoms they observe from them sometimes to me as they like most of the time to be spent with them while the ward is full and I’m rushing to finish medication.”

“Sometimes I think that I’ll come back to listen to the problem but forget and think about it when I’m at home.”

The participants who had knowledge of the management of side effects immediately told the doctor about them. If side effects are severe biperiden medication or an injection is given intramuscularly or administered orally to counteract the side effects. The management of side effects involves careful nursing intervention, client and family education. The earliest and more dramatic extrapyramidal side effects occur in the first days of medication treatment, sometimes after a single dose of medication (Kneisl & Trigoboff 2008:853). The extra pyramidal side effects involve bizarre and severe muscle contractions. These reactions are physically painful and are frightening to the individual. They are reversible if the patient is given a biperiden injection or an orphenadrine tablet.

3.4.1.3 Mental health care user might relapse

Participants feared that stabilised mental health care users might relapse whilst they were still in the medical ward. Although mental health care users were still taking their prescribed psychotropic drugs, participants feared that physical illness might trigger mental illness. In diabetic patients, if the sugar level is low, the patient will be disorientated, confused and have hallucinations (Sadock & Sadock 2007:368). The patient’s sugar levels need to be monitored closely to avoid a misdiagnosis and to be put on relevant treatment. If the condition is uncontrollable, referral will be required to another department for further management.

An epileptic patient might experience a period of confusion after an attack of seizure, having post-ictal psychosis (Sadock & Sadock 2007:362). All investigations need to be done by doctors and nurses to exclude any medical conditions before the patient is diagnosed as mentally ill. Patients who are suffering from HIV/AIDS may develop a mental illness for several reasons if they do not want to accept the diagnosis. The patient may have a multitude of physical problems (Kneisl & Trigoboff

2008:680). The quality of the nurse-patient relationship is intensified through the additional contact required in giving physical care. The stabilised mental health care user needs to adhere to prescribed psychotropic medication and antiretroviral drugs. Most of them may develop psychosis secondary to a general medical condition.

Some participants were unable to intervene when the mental health care user relapsed. Such relapses caused other medical patients to feel unsafe and afraid in the ward. As a result of this, they ended up requesting to be discharged. Participants were expected to use relevant skills to calm the mental health care users. Inability to intervene leads to frustrations and fears to the medical staff. Participants are expected to understand what mental illness is and how it is treated. Collaboration with mental health care nurses helps medical staff to overcome fear and increase competence in caring for stabilised mental health care users (Reed & Fitzgerald 2005:249).

3.4.2. Stigma

Uys & Middleton (2004:75) associate the social exclusion of and discrimination against mental health care users with the stigma that is attached to mental illness and put the blame on the media which stereotype the mentally ill as violent. These authors argue that stigma stains or scars the person's reputation and it brands a person in a negative way in the eyes of society. They argue that society has misconceptions about mental health care users and this is part of the reason why many mental health care users and their families are socially shunned, cannot find work, housing or friends. Nevitt (2005-2014) argues that, as long as stigma is rife, exclusion and discrimination of mental health care users cannot decrease. These authors further argue that stigma focuses attention on people who are recipients of rejection and exclusion rather than those who perpetuate the unjust treatment, hence many authors focus on the effect of stigma on the mental health care users.

It emerged from the findings of this study that professional nurses working in medical wards stigmatised stabilised mental health care users. The data revealed that some participants did not accept these users, even though they were seen as stable and no signs of aggression were observed. Mental health care users may possibly have had visual and or auditory hallucinations in spite of their prescribed psychotropic drugs being administered. Visual hallucinations are false impressions involving

sense of sight whereby one sees objects that are not seen by other people (Sadock & Sadock 2007:283). Auditory hallucinations are false perceptions of sound, usually voices, but also other sounds, such as music (Sadock & Sadock 2007:274).

Stigma negatively impacted on the relationship between the participants and stabilised mental health care users as communication was limited. If it happened that the participant initiated the conversation, the user sometimes did not respond at all or minimal verbal communication was noticed.

“Mental illness has lot of stigma attached to it, people do not understand mental illness.”

“Mhmm”

“Avoiding eye contact”

“There is also stigma attached to mental illness because even if you have not done anything wrong you will be labelled with bad names.”

“We also perceived mental health care users as dangerous.”

The participants who accepted mental health care users did not stigmatise them and this improved access to mental health care users. Collaboration with mental health care users helped them to be free from discrimination.

“I think sometimes it is right to admit stabilised mental health care users in medical ward so that they can see and feel that they are accepted by other nurses in the hospital.”

The participants who avoided talking and interacting with these mental health care users stated that there were also other patients who needed to be cared for in the ward.

“I don’t have enough time to listen to all the problems of patients in the ward as we are short staff in the unit.”

“Users are attention seekers I know them they like to be owned by all of us.”

In Ndetei, Khasakhala, Mutiso and Mbwanyo (2011: 225) it is stated that, with regard to negative attitude towards people with mental disorders, the general public holds certain stereotypes which are associated with believing that psychiatric patients are dangerous and can cause harm to others. One of the strongest stereotypical beliefs of the general public about psychiatric patients holds that psychiatric patients have a tendency to cause injury or harm to others and to property (Ndetei *et al.* 2011: 225).

Such stereotypes are linked to stigma attached to mental illness and thus involve the violation of their rights.

Many people in the community have a tendency to provoke stabilised MHCUs because they had been admitted in a mental institution and are on monthly treatment. People think of stabilised MHCUs as wandering psychotics and they are viewed as worthless, dirty, senseless, dangerous and unpredictable. These lead to the discrimination against MHCUs. Many people in the family and in the community do not want MHCUs to perform tasks or to involve them in meetings, even if they are stabilised. These people do not trust MHCUs to be able to do tasks well or be involved in social gatherings (Ndetie *et al.* 2011:225).

Negative attitudes towards stabilised mental health care users were based on values and beliefs that had been shaped by environmental and social influences. Negative attitudes led to avoidance of and discrimination against mental illness. Some participants felt that although they cared for stabilised users, there still remained a notion that mental health care users are labelled and treated differently. Participants did not trust users because of the stigma attached to them due to being mentally ill, although they were stable. Mental illness is just like any other illness but compliance is very important and one must not stop treatment without consulting a health care practitioner.

“Patients present with physical needs but often have mental health problems masked by physical symptoms.”

A negative attitude was shown by participants who labelled stabilised mental health care users in the wards by calling them by their psychiatric diagnosis. This was often noticed during report giving when the shifts were changing.

“This schizo brought in treatment from home please confirm from doctors that it is the right treatment and we also requested family members to bring clinic book tomorrow.”

“It is difficult to issue this psychiatric treatment to this bipolar patient because I even don't know the names and colour or shape of the tablets. When these patients are admitted in the ward, treatment administration period is delayed because it takes time to search for their treatment in the medication trolley as we are unfamiliar with their treatment.”

Unlike medication for medical illnesses, psychiatric treatment is stigmatising (Kneisl & Trigoboff 2008: 845-847). An administration of medication demands a nurse to

give the right medication, the right dose, follow the right route at the right time, for the right patient with the right technology. A medication may be ordered by mouth (PO) for routine administration, but the patient may refuse it. The nurse needs to use assessment skills, to determine whether the patient needs a liquid, a pill, a quick dissolving formulation or an injection when necessary (PRN injection). The nurse must also be attuned to the circumstances of adjunct pharmacotherapy (taking different medications at the same time). This demonstrates how symptoms can become unmanageable for a patient when adjunctive therapy is discontinued.

3.4.3 Myths

Myths refer to colourful stories that relate the origins of humans and the cosmos (Magoulick 2003). Attitudes towards myth vary greatly. Some regard it as a source of spiritual growth, while others see only falsehood. Some see in myth the distinct character of particular cultures.

There are many myths about mental illness. Mental illness is common and it affects people of all ages, educational and income levels and cultures. There is a belief that people with mental illness are violent. The fact is that people with mental illness are no more dangerous than the rest of the population. They are more likely to harm themselves or be harmed than they are to hurt other people.

Participants indicated that mental illness is contagious. They stated that, if they nursed patients with a history of mental illness, they would automatically acquire mental illness.

“We are not safe to nurse stabilised mental health care users as mental illness is contagious.”

“Institutions for mental illness were built in isolation, I think the motive behind was that patients were not supposed to be nursed with other diseases.”

3.4.4 Training

Training has to do with processes and skills underlying continuing intrinsic motivation to learn toward a definition of motivational skills training interventions (McCombs 1984:199).

Participants in this research demonstrated a strong desire to help stabilised mental health care users and to protect their rights. Collaboration with mental health services will increase education and support for nurses, improving comfort levels and

confidence to provide care. Such collaboration may assist nurses to facilitate the inclusion of appropriate care for people with mental health problems into the mainstream of medical wards.

All categories of nurses have a responsibility to be knowledgeable about mental illness and how to manage it, as this assists in gaining skills (South African Nursing Council, Regulation 425 of 1985). There are professional nurses in medical wards who are trained in psychiatric nursing but lack knowledge and skills and are not confident that they could nurse the stabilised mental health care user who might relapse, in spite of having cared for mental health users during their training as student nurses. Such training will assist the nurses to recognise factors that trigger mental illness and they will therefore be able to prevent these factors resulting in a relapse. The attitude of fear has an impact on the ability to carry out the nursing care. The professional nurses end up avoiding stabilised mental health care users.

3.4.4.1 In-service training

The participants, who expressed a more positive attitude to caring for stabilised mental health care users, felt comfortable at the end. They related this to positive perceptions in caring for stabilised mental health care users with medical conditions resulting from education and interaction with the multidisciplinary health care team in the mental unit.

“I wasn’t comfortable initially but the more information I’ve got about that it makes me feel much better.”

“I’ve been getting in-service education on what to look for in stabilised mental health care user and how to take assessment data during admission period. I felt a bit more confident in assessing them.”

Participants believed that nurses working in medical wards behave negatively because they have limited skills and lack knowledge to care for stabilised mental health care users. Participants indicated that they would like to be able to provide the appropriate care if provision was made for training to acquire more skills so as to be competent in the ward. Participants also expressed the need for a broader introduction to mental health issues in the general nurse curriculum.

“We have no insight in mental health illness; we don’t have experience at all.”

Nurse participants compared their lack of mental health education with doctors, whom they perceived to be in a similar situation.

“The drugs that the patients are on are not suitable and our doctors don’t have much idea. Doctors as well as nurses need to be educated.”

It is important to be knowledgeable about anti psychotropic drugs, their generic names, indications, contra indications, strengths, dosages, routes of administration, side effects and their management. All professionals should receive formal mental health education in the curriculum and this would go some way to ensure that patient –centred care is delivered.

“When the patients come here staff is not given a full history by their family members that they have a psychiatric illness and they are on treatment.”

“We need to be accurate if patients are on psychiatric treatment.”

“If it’s difficult to assess the patient, we collect the data from the relatives.”

Data can be collected within a few minutes or over a long period. There are two levels of assessment: information-gathering during initial contact with the stabilised mental health care user in order to determine the immediate needs; and information-gathering over a period during which the team member or a nurse attempts to understand the patient while gathering information (Uys & Middleton 2007:169).

3.4.4.2. Adopt a positive attitude

Emanating from findings of this study, participants felt that negative attitudes that they displayed towards stabilised mental health care users were not correct. From quality circles and climate meetings they suggested that every nurse in medical wards should accept and treat the patients equally. As stated by the Minister in the National Department of Health, a positive attitude is one of the six priorities that the nurse must have towards patients (Doctor Motsoaledi, Department of Health budget speech 2010). Positive attitudes need to be emphasised in all meetings and suggestions, compliments and comments to be welcomed. It was suggested that attitude of nurses towards patients with a psychiatric diagnosis should be added to agendas.

“Every time you like to request some more from the food, you are not the only patient in this ward.”

In Reed and Fitzgerald (2005: 252) some general nurses expressed more positive attitudes towards caring for people with mental health problems, as they indicated the need to make them comfortable and that caring for the patients gains positive experiences.

An emotional climate is created largely by the attitudes of the staff (Uys & Middleton 2007:227). Negative attitudes lead to anti-herapeutic behaviour such as rigidity, teasing, withdrawal and formation of cliques. The nursing staff needs to take the initiative in interaction and showing special interest in each patient.

The continuous education and interaction with mental health care teams increases the nurses' knowledge. There is a weekly in-service plan for nurses to equip others from other departments on management of MHCUs (Ndeti *et al.* 2011:234). When the concerns of the nurses are addressed by management, they gain confidence in the system that support them and will express a greater sense of control over their responsibilities. Nurses who are supported and given opportunities to access assistance from the mental health team, feel more secure and less anxious about caring for mentally ill people (Reed & Fitzgerald 2005:252). Provision of increased support and access to assistance, allow the nurses to gain knowledge and understanding of mental illness and thus reduce their anxiety and fears.

3.4.4.3 Dispel myths and fear

Participants indicated that there are many myths and fears connected to caring for stabilised mental health care users in a general hospital setting. The nurses in the medical unit presented their complaints and fears to the hospital management, but nothing was done to allay their fears. According to Reed and Fitzgerald (2005: 252) there is no appropriate help when it is needed. In the psychiatric ward, the doors are always locked. In every ward there are two security officers allocated for both, day and night shifts. These security officers are trained in how to handle MHCUs. It is necessary to have back-up on duty, so as to care for the nurses so that they would feel safe in the ward. The situation is worse after hours and during week-ends or public holidays. It may be necessary for managers to respond to the complaints of the general nurses to allay their fears before a serious situation arises. Nurses need to know that stabilised MHCUs are sick just like any other ill person (Kapungwe, Cooper, Mwanza, Mwape, Sikwese, Kakuma, Lund & Flisher 2010:200). General

nurses need to be given information about stabilised MHCUs prior to their admission to a general ward so that they may be prepared with strategies for dealing with these MHCUs from the onset (Sharrock & Happell 2002:31).

Some general nurses stated that they dislike caring for people with mental health problems and, if they had a choice, would not do so. Nurses need to build nurse-patient relationships by always communicating with MHCUs.

They suggested that these myths and fears need to be addressed in part-time courses. A list of attendees would need to be drawn up and displayed each month and if there were changes, they needed to be known in advance before the due date. The participants who attended the course would share the information received in the courses with others.

“There is misconception that mental illness is infectious.”

The information could be distributed in the form of management-by-objective and departmental demonstrations. Even then questions and suggestions will be posed. At the end of each month, a report could be presented so as to know how many staff members attended the course.

3.4.4.4 Referral systems

The findings that also emanated from this study were that the patients need to be screened thoroughly before referral to a specific ward. The members of the multidisciplinary team usually undertake the patient's assessment, often repeating the same questions and regularly keeping their own professional documentation apart in different formats. Information could be shared through communication by means of awareness days or campaigns. This would improve the care of patients. It would also prevent professionals from blaming each other for failure in management of patients.

Participants identified that stigma relating to mental health issues needed to be openly discussed between professionals, families and patients. Participants wanted opportunities to foster a more open approach in talking about mental health issues, although they acknowledged that this would depend on the collaboration of all disciplines.

“We often have bad attitudes when we read from notes that the patient we are admitting is having history of mental illness forgetting that even them they are human beings who may suffer from any other illness.”

Participants advised that referral systems of stabilised mental health care users should be explained in more detail in awareness day campaigns. The person who lives with the stabilised mental health care user needs to be available to give a history about the behaviour of the mental health care user before admission. The data would help the doctor to prescribe correct medication.

In the general hospital setting, nursing staff from the mental health care unit could be advised to have different stalls where they could advise other professional nurses about the care of stabilised users when they are admitted in their ward for a medical condition. Staff from the mental health care department suggested that questions could be invited from the audience.

The referral involves transfer of a patient for further management to another department (Uys & Middleton 2007:70). When doing a referral, a standardised form may be used. This should be addressed either to a doctor or an appropriate professional. A copy of the referral letter should be kept in the patient's file. The following components are essential parts of a referral: patient's name, referring clinic/service, person making the referral, diagnosis of the patient (if available), treatment the patient is currently receiving, the reason for the referral, for example: “The patient is a known mental health care user on treatment and stable now, but he is presenting with a medical diagnosis” and what is requested, for example: “Please admit for further management”.

3.4.4.5 Specialist psychiatric nurse in medical ward

According to the American Nurses Association (ANA), the American Psychiatric Nurses Association (APNA) and the International Society of Psychiatric Mental Health Nurses (ISPN), (2007), the specialist psychiatric nurse is a licensed registered nurse who is educationally prepared as a clinical nurse specialist or a nurse practitioner at the master's or doctoral degree level in the speciality of psychiatric–mental health nursing (Kneisl & Trigoboff 2008:21–22). Advanced practise psychiatric- mental health nurses may also seek certification at the advanced level through the American Nurses Credentialing Centre (ANCC). The

psychiatric mental health nurses may use the initial CS (certified specialist). The advanced- level certification is a means of protecting the consumers.

The participants suggested that a specialist psychiatric nurse in medical ward could assist and educate general nurses in the care of stabilised mental health users who are receiving care in a medical setting. This specialist psychiatric nurse could be consulted for guidance and advice in the medical ward when there is a problem. The specialist would serve as a patient's advocate and facilitate communication between doctors and patients. When there is a need, the specialist could advise the doctor about the treatment which the user is receiving.

Furthermore, the specialist psychiatric nurse could counsel participants who care for these users and refer them when necessary to other members of multidisciplinary team.

“Tell me how you coped last time when you lost a member of your family.”

“You were told that a stabilised mental health care user is coming for admission in your ward, how did you feel?”

It was advised that the presence of a specialist psychiatric nurse on site could improve the accessibility of mental health services in the medical wards. The specialist psychiatric nurse's role functions are to use prescriptive authority, procedures, referrals, treatment and therapies in accordance with state and federal laws and regulations (Kneisl & Trigoboff 2008:21).The specialist psychiatric nurse conducts individual, group, couples and family psychotherapy using evidenced-based psychotherapeutic frameworks and therapeutic nurse-patient therapeutic relationships. The specialist psychiatric nurse would provide consultation to influence an identified plan, enhance the abilities of other clinicians to provide services for patients and effect change (Kneisl & Trigoboff 2008:21).

3.5 CONCLUSION

This chapter has presented the analysis of the study findings. Also presented in this chapter the data, obtained through the transcribed interviews were analysed, and themes, categories and subcategories were identified to describe perceptions of professional nurses regarding the care of stabilised mental health care users in a general hospital setting was done.

The participants experienced problems in caring for stabilised mental health care users with a medical diagnosis in medical wards. These problems are the following: lack of knowledge; lack of experience and psychiatric nursing skills as characterised by the participants being unable to identify signs of relapse; and lack of knowledge about psychotropic medication. Negative attitudes of participants towards mental health care users result in poor relationships between the staff and mental health care users characterised by a lack of response or minimal verbal communication. Continuing education related to stabilised mental health care users with medical conditions in general medical ward needs to be provided.

Chapter 4 provides a discussion of the conclusions, limitations and recommendations pertaining to this study.

CHAPTER 4

DISCUSSION OF RESULTS, CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

The analysis of the data, and identification and discussion of the themes related to the perceptions of professional nurses regarding the care of stabilised mental health care users in a hospital setting were presented in chapter 3. This chapter focuses on a discussion of results, conclusions and recommendations in response to the set objectives of this study which were to:

- Explore and describe the perceptions of general nurses about the stabilised mental health care users who are admitted in a medical ward for medical conditions,
- Determine the reasons why the nurses allocated in a medical wards are unwilling to render care and treatment to medically ill stabilised mental health care users and
- Make recommendations based on the results.

4.2 DISCUSSION OF FINDINGS

The findings arose from verbal comments made by professional nurses regarding their fears related to caring for mental health care users in a general hospital setting, the stigma attached to mental health care users once they were admitted to a medical ward with a medical diagnosis; and the myths around mental illness. These factors formed the focus of this study.

The results revealed that there are obstacles that translate into fears regarding caring for stabilised mental health care users in medical wards. For purposes of this discussion, the obstacles that contributed to the unwillingness of general nurses to care for stabilised mental health care users are lack of knowledge with regard to psychiatric nursing skills, psychopharmacology and psychopathology. Other obstacles were poor communication between the professional nurses and stabilised mental health care users which resulted in lack of response or minimal verbal communication when a conversation was initiated. The professional nurses had a negative attitude towards stabilised mental health care users.

There seemed to be poor trust in stabilised mental health care users in medical unit as they are believed to be unpredictable. Non-acceptance was due to the possibility of visual and auditory hallucinations.

“Once the mental health care user suffered from hallucinations sometimes he becomes destructive, just tear notices hanging against the wall and pushed pot plants.”

The professional nurses had a feeling that mental illness is contagious. Professional nurses perceived mental health care users as dangerous.

The results revealed that the following strategies have a potential to promote quality nursing care for stabilised mentally health care users in medical ward, namely in-service training; empowering nurses to adopt a positive attitude when nursing mental health care users; dispelling myths and fears; improvement of the referral system and allocating a specialist psychiatric nurse in a medical ward. The recommended strategies could be used as a framework for training general nurses to enable them to provide quality care to stabilised mental health care users in a medical ward.

4.2.1 Fear

4.2.1.1 Lack of knowledge, experience and psychiatric nursing skills

The fear resulting from the general nurses' lack of knowledge in relation to psychopathology; lack of experience in nursing mental health care users; and incompetence in psychiatric nursing skills were found to influence their ability to provide quality care to stabilised mental health care users. Professional nurses believed that they possessed a limited ability to help stabilised mental health care users who are still continuing with their medication to prevent relapse. The nurses in medical wards lack knowledge about what mental illness is, what causes it and thus unable to identify signs of relapse. This leads to mismanagement of mental health care users, with nurses saying:

“Mmm, keep your distance. Yeah, probably not the best treatment for them, but.... Well it's my way of coping. It's an avoidance issue.”

“Nurses have no insight to mental health care users Nurses do not have the same input to their training programme.... They have no experience at all.”

King, Judd & Grigg (2001) recommended the need for on-going support and education to provide effective care.

4.2.1.2 Lack of knowledge of psychotropic medication

The data revealed that professional nurses lacked knowledge of psychotropic medications, dose, side effects and management thereof. When stabilised mental health care users are admitted to medical wards, physicians check current psychiatric treatment before prescribing other medical treatment, to avoid drug interactions. Drug interaction involves any modification of the action of one drug by another drug (Gutierrez & Queener 2003:4). Interaction may either increase or decrease the action of the drugs involved. Drugs that increase or decrease the activity of another drug can alter the biotransformation of the antipsychotic drugs resulting in higher or lower drug concentrations in the body. Adverse effects can be seen or reported.

This study has found that stabilised mental health care users are ignored by professional nurses in medical wards. They are not cared for when they complain of side effects which may be painful. Mismanagement of side effects causes other patients in the ward to be uncomfortable with staying with mental health care users. When this mismanagement of side effects occurs, the stabilised mental health care users know which treatment should be administered to counter the side effects.

“Sister, please give me the small yellow tablets or injections because I’m seeing everything double.”

4.2.1.3 Mental health care users may relapse

Data revealed that mental health care users are not properly cared for in medical wards. Stabilised mental health care users may relapse if the professional nurses in the ward entertain fears about them. A physical illness may trigger a mental illness. The nurses need to care for a patient’s physical, social and mental well-being. The World Health Organisation (WHO) (2003) states that people with mental disorders have the right to receive high quality treatment and care delivered through responsive health care services. They should be protected against any form of inhumane treatment and discrimination. Stigma and discrimination are often linked to violation of human rights. WHO (2002) further affirms that it is a right of all people to be free from discrimination.

All observations and assessments need to be done thoroughly and at the stipulated time for all patients in the ward. It is important to record and report any abnormalities

to the nurse manager and the doctor to prevent complications. This is a factor that will assist in preventing relapse in mental health care user illness. Nurses need to observe mental health care users closely when they relapse and notify the doctor about the relapse. As nurses in medical wards are unable to intervene, early notification implies early initiation of treatment if necessary. This will allay the nurse's fears of the patient becoming violent.

4.2.2 Stigma

4.2.2.1 Poor communication

Communication is defined as a two way process where one talks and the other listens; an interchange of thoughts, opinions or information by speech, writing or signs (Oxford dictionary, 2005). The data revealed that stabilised mental health care users had minimal verbal communication with the professional nurses and did not respond to their requests.

“Patients are labelled and staff takes this on and do not look beyond this.”

Professional nurses talked about the stigma of having a mental illness. They also communicated that mental health care users are incorrectly labelled because of one or two episodes of inappropriate behaviour.

“Mental health care users coming into hospital are sometimes just labelled as confused.”

Mental health care users, like all South Africans, have a right not to be discriminated against in terms of race, ethnicity, religion, sex, age, disability or sexual orientation, as enshrined in the Constitution of the Republic of South Africa (Act No. 108 of 1996). In Monjok, Smesny & Essien (2009: 23), discrimination is described as an aspect of stigma and a form of exclusion or restriction of expression, marginalisation, or prevention from access to something or services. In Birkman, Sperdip & Smith (2006: 157-165) it is stated that patients who are stigmatised and discriminated against tend to relapse. The authors furthermore state that stigma contributes to isolation, loneliness and chronicity.

The results of this study demonstrate that discrimination against mental health care users is evident. This discrimination is the result of a lack of knowledge and the stigma attached to mental illness. Mental health care users are isolated by

professional nurses in medical wards. Nurses expressed a clear dislike of caring for mental health care users due to the manifestation of strange behaviour caused by mental illness. It is difficult to understand mental illness because the interpretation of strange behaviour varies from person to person and from culture to culture. The diagnosis of mental illness is based on a cluster of symptoms. A cluster of symptoms allows the mental health care practitioner to arrive at a specific diagnosis. Labelling of mental health care users with an incorrect diagnosis may have the consequence for them of loss of dignity. It is harder for mental health care practitioners to diagnose mental health care users on the basis of symptoms. Nurses perceived that, improving their knowledge, skill and experience in caring for the stabilised mental care users, will improve their ability to help reduce stigma attached to mental illness.

Negative perceptions may have influenced the nurses' beliefs that it is difficult to care for stabilised mental health care users, and that there is a high risk of danger in caring for such patients in a general hospital setting. The nurses highlighted the need to feel more competent and safe to improve their attitudes towards caring for stabilised health care users. The negative attitude and ability of professional nurses in providing nursing care to stabilised mental health care users has also been shown to be poor by Sharrock & Happell (2002: 24-33).

4.2.3 Myths

4.2.3.1 Perceptions of mental illness as contagious

The professional nurses perceived that mental illness is contagious;

“One can acquire it by nursing mental health care users.”

According to Thomas Anderson (2012) mental illness is contagious; it is spread by toxic environments, virus and bacteria. Anderson's opinion proves the misguided belief that people have with regard to mental illness. A person's environment and perception can influence the mental state to trigger conditions like high anxiety, post-traumatic stress disorder, eating disorder and self-harm (Fritzie, 2012).

Professional nurses experienced stress due to the belief that mental health care users are violent. Other studies (Grig & Sharrock 2002; King et al. 2001) influenced negative nurses' attitudes to providing care for stabilised mental health care users.

4.2.4 Training

4.2.4.1 In-service training

Jacoby (2004) defines training as the acquisition of knowledge, skills and competencies. The author further mentions that training has the specific goal of improving one's capability, capacity and performance and people within many professions and occupations refer to this kind of training as professional development.

Mental health nurses have rendered in-service education, advice and support to the professional nurses allocated in medical wards (Reed & Fitzgerald 2005: 255). The provision of training helps the professional nurse to acquire skills and competence to promote mental health and intervene in mental illness. Competence refers to the ability of a practitioner to integrate professional attributes including, but not limited to, knowledge, skills, judgement, values and beliefs required to perform as a nurse in all situations and practice settings (Nursing Act No. 33 of 2005).

In-service training for nurses generally is done weekly on Tuesdays at 11h00 in medical wards 1, 7, 8 and 14 of the Cecilia Makiwane Hospital where the researcher is employed. Topics to be discussed are selected by the medical staff, and preferably focus on the problems they encounter. The operational manager for the medical department requests an instructor from the mental health department to conduct in-service training if the topic is related to mental illness. The training assists in reducing the fear and anxiety of professional nurses in a medical ward as they gain greater knowledge and understanding of what mental illness is, as they had indicated that they had little or no experience of caring for mental health care users with medical problems (Arnold & Mitchell 2008:31).

“The more information we’ve got about mental illness makes you feel a lot better.”

It is recommended that the mental health team and medical staff interact regularly to share problems that they encounter in the nursing care of mental health care users.

Mental health education provides individuals, groups and families with the knowledge of and insight into all aspects of the promotion of mental health and prevention of mental illness (Uys & Trigoboff 2007:216). Professional nurses were

assisted to gain competency in solving problems they encountered in relation to mental illness. This competency reduces the chance of professional nurses becoming ill due to stress caused by their inability to solve problems around stabilised mental health care users. In service training allows professional nurse to find alternative coping mechanisms and to master their feelings.

In-service training is inclusive of education about psychotropic medication. Just like any patient, the stabilised mental health care users must only take drugs prescribed by doctors. A professional nurse must administer the treatment according to doctors' prescriptions. When administering medication, the nurse is supposed to observe whether the patient swallows the medication.

Professional nurses appeared to understand the importance of in service training to acquire more skills and competence about mental health and mental illness.

“We just give medication for psychiatric patients and some of the professional nurses are not familiar with the psychotropic medication.”

The professional nurses stated that in-service training would provide them with knowledge and skill in administering psychotropic medication.

4.2.4.2 Adopt a positive attitude

Professional nurses conveyed that mental health care users present with mental needs but often have physical problems masked by mental symptoms, such as being withdrawn, forgetful, challenging or aggressive (Arnold & Mitchel 2008:30). Mental health nurses highlighted the need for professional nurses in medical wards to feel more competent, safe and supported. This would improve the attitude towards caring for mental health care users with medical illnesses. During climate meetings, it was emphasised that professional nurses need to adopt a positive attitude in the medical ward in order to be able to effectively care for mental health care users.

Professional nurses in a general hospital should have a positive attitude towards their patients irrespective of their diagnosis. Some professional nurses have a negative attitude towards caring for stabilised mental health care users due to the stigma attached to mentally illness. These nurses expressed a clear dislike of caring for the mental health care users. They also stated that they did not have enough time to care for “*up and about*” patients. The medical nurses are more accustomed to treating bedridden patients. These nurses also indicated that they are not educated

to care for mental health care users. Attitudes towards mental illness may be based not only on experience, but also on values and beliefs that are shaped by environmental and social influences (Olade 1983:93 - 97). Professional nurses were of the opinion that they needed more time to engage with mental health care users compared to other patients in the ward. The nurses reported that when there are high demands in the ward, mental health care users may be left for last and may only be cared for if there is enough time available.

4.2.4.3 Dispel myths and fear

Although data revealed that professional nurses had attended part-time courses during which they were educated about mental illnesses, professional nurses continue to adhere to myths and fears about mental illness. Seminars were devised with the specific objective to dispel these unfounded myths and fears. Reviews of management were done weekly to enforce education on mental illness and its management.

4.2.4.4 Referral systems

Stabilised mental health care users are admitted to medical wards from medical outpatient departments, psychiatric outpatient departments and casualty departments. They arrive with referral letters with a doctor's assessment notes and prescribed treatment. The professional nurses were educated about the referral system during awareness days and/or campaigns. During mental illness awareness month, generally July of every year, mental health nurses educate general nurses about mental illness, its signs and symptoms and its management. Low levels of awareness of mental illness among medical staff leads to unmanaged medical problems in stabilised mental health care users. Stigmatisation and negative attitudes contributed to poor care of stabilised mental health care users as they had a history of mental illness and psychiatric treatment in their referral letters. In October, during mental health awareness month, professional nurses are encouraged to educate relatives of mental health care users about acceptance of, accountability and commitment to their mentally ill patients.

4.2.4.5 Specialist psychiatric nurse in medical ward

The professional nurses verbalised during interviews that they received support from colleagues, managers and supervisors. The findings of this study revealed that there were no specialist psychiatric nurses in medical wards. The participants said that it

would be advantageous for patients to have specialist psychiatric nurses visiting the wards. It would improve engagement with all members of the multi-disciplinary team by facilitating guidance and advice on the management of stabilised mental health care users. Members of the multi-disciplinary team include nurses trained in psychiatry, psychiatrists, psychologists, social workers and occupational therapists. The participants indicated that specialist psychiatric nurses should visit the medical wards when they receive consultation or referral letters from physicians. The specialist psychiatric nurse could conduct individual, couple, group and family psychotherapy on their visit as per consultation or referral letter. This will improve nurse-patient therapeutic relationships. The specialist psychiatric nurse would provide consultation to assist with the management plan, enhance the abilities of other clinicians to provide services for mental health care users and effect change.

4.3 LIMITATIONS

The study had the following limitations. The sample size was limited to voluntary respondents with an interest in participating in the study. The characteristics and views of those participants who did not participate in the study cannot be known. The small sample size of the qualitative design of the study implies that the results cannot be generalised.

4.4 RECOMMENDED STRATEGIES TO IMPROVE CARE OF STABILISED MENTAL HEALTH CARE USERS IN A GENERAL HOSPITAL SETTING

The strategies outlined here will be disseminated to various levels of Management of the Cecilia Makiwane Hospital. The results of this study will be presented in a research symposium that may be organised by the university. A manuscript will be submitted for publication to one of the peer-reviewed journals. A workshop or seminar and a presentation at a conference will be organised to communicate the report so that professional nurses will be informed about recommendations which will enable them to render holistic care to medically ill mental health care users.

The recommendations made should be considered at a national level in order to improve the quality of nursing care to stabilised mental health care users admitted in medical wards..

4.4.1 Adequate knowledge, experience and psychic nursing skills

There is a need for professional nurses to have adequate knowledge, experience and psychiatric nursing skills to care for stabilised health care users who are suffering from medical conditions. These will help them to improve the standard of care in the medical wards.

4.4.2 Knowledge about psychotropic medication

Every stabilised mental health care user who is admitted to a medical ward is admitted with prescribed treatment by both the psychiatrist and the physician. Professional nurses need to know all prescribed drugs, the dose, side effects and management of side effects. When the mental health care users develop side effects the professional nurse needs to manage them immediately.

Nurses in medical wards need to know how to manage scheduled drugs. Psychotropic drugs are stored in drug cupboards and refrigerators. Drugs are ordered on Mondays and fetched on Wednesdays. During shift changes, drugs are controlled by both teams. Before the professional nurses administer drugs to the patient, they count the stock available and compare it to the balance available in the drug register. After administration of drugs to the patient, the professional nurse makes an entry in the drug register. The drugs are also controlled by the area manager and the professional nurse.

4.4.3 Prevention of mental health care user relapse in medical wards

Professional nurses should not allow their fears concerning stabilised mental health care users to affect their management of the stabilised mental health care user. Nurses should not stigmatise and discriminate against stabilised mental care users. This stigmatisation and discrimination can be reduced with continuous education for the professional development of nurses.

4.4.4 Good communication

In the ward, there must be good nurse-patient relationships so that there could be effective communication. Trust needs to be established between the two parties to improve communication. Communication skills are indispensable for all nurses, as health outcomes depend on a good nurse patient relationship. As such, professional nurses should listen actively, show empathy, use open and closed ended questioning techniques, and manage their nonverbal communication. During a

conversation with a patient, eye contact needs to be maintained. During a consultation between a nurse and a mental health care user privacy needs to be ensured to promote the dignity of stabilised mental health care users. Confidentiality should be maintained at all times with regard to mental health care users.

According to the Mental Health Care Act (Act No.17 of 2002), service users have a right to communicate with service providers in confidence. Information gathered should be used to facilitate treatment and should remain confidential. Consent must be given by the mental health care user if the information needs to be disclosed to another person.

O'Daniel & Rosenstein (2008: 20) consider that miscommunication and the lack of sharing information is a major barrier to collaborative working. Apart from excellent communication, collaboration requires shared responsibilities, goals, access to patients, resources and joint decision making (D'Amour, Ferrada-Videla, San-Martin, Rodriguez & Beaulieu 2005:116 - 131).

4.4.5 Not contagious

Professional nurses need to be made aware that mental illnesses are not contagious. Professional nurses must be comfortable nursing stabilised mental health care users as their illness is not contagious. Mental health care users should continue taking prescribed psychiatric treatment in the medical ward to avoid relapse.

4.4.6 In-service training

To ensure that the professional nurses are knowledgeable and competent, they must be kept up to date with current knowledge and trends in their respective areas of care. This should provide continuous staff development in the form of in service training. In-service training programmes should be well organised with clear objectives, stating dates and topics to avoid time clashes, therefore allowing medical staff to attend. The programme can be consolidated by both medical and mental health staff.

Professional nurses need a broader introduction to mental health issues in the general nurse curriculum, which should include the identification of signs and symptoms of common mental illness and their management.

4.4.7 Adopt a positive attitude

Professional nurses need to have a positive attitude towards mental health care users so as to care for them effectively. Positive experience promoted through education and support is required for nurses to improve care and attitudes. Collaboration of professional nurses with mental health care nurses helps the professional nurses to overcome fear and therefore increase competence in caring for people with mental illnesses (Reed & Fitzgerald 2005: 249).

4.4.8 Dispel myths and fear

Professional nurses need to be educated about mental illness to dispel the myths and fears that they entertain regarding mental illness. Nursing care of mental health care users should improve after dispelling of myths and fears. Continued performance development in the form of in service training will assist in this strategy.

4.4.9 Referral system

Clear guidelines should be available in each ward to explain how the mental health care user should be cared for in a hospital setting. Medical staff must have the knowledge and, skill to manage mental health care users with medical problems.

4.4.10 Specialist psychiatric nurse in medical ward

There is a need for specialist psychiatric nurses to be allocated to medical wards for guidance and advice. The specialist will conduct individual, couple, group and family psychotherapy. The specialists will also provide consultation to influence the management plan, and enhance the abilities of other clinicians to provide services for mental health care users and effect change.

4.5 IMPLICATIONS FOR FURTHER RESEARCH

The researcher identified possible areas for further research which could have an impact on employees' improved work performance and high quality patient care. These include the need to perform the same type of investigation with other nursing categories of staff, irrespective of gender; the need to investigate the extent of the impact of stabilised mental health care users on the work performance of professional nurses and the need for development of guidelines on management of stabilised mental health care users in medical wards, which will apply to all staff members.

4.6 APPLICATION OF FLORENCE NIGHTINGALE'S THEORY TO THIS STUDY

The Florence Nightingale's Theory as discussed in Lancaster & Stanhope (2006), is aligned to the processes followed in conducting this as well as to the findings of this study. This theory provides a starting point for collecting facts in a systematic way. Florence Nightingale's conceptual model and theory identifies the concepts that are essential for nursing and guides the actions that nurses should implement in their daily activities.

The researcher followed a systematic approach in the form of a research process when conducting this study which assisted in studying the identified phenomena. Following the research methodology, the researcher assessed the situation and formulated the relevant research questions and research problem.

The researcher selected the holistic model theory because of the unique feature of the client-centred approach by searching for wisdom on perspectives on illness, the person, their environment and holistic nursing.

The researcher made use of concepts, illustrations, theories and models to support the research topic as stated in (Burns *et al.*, 2009: 93). Rossouw (2003:100) states that a theoretical or conceptual framework means that the concepts of research are identified and linked to each other by means of a literature study of existing conceptual frameworks. The main concepts that had been utilised were the person, health and nursing (Selander 2010: 82).

This study was done in medical wards (ward 1, 7, 8, and 14) of the hospital in which the researcher works. The researcher identified challenges with regard to the care of stabilised mental health care users in this hospital setting. The researcher selected participants from medical wards to explore and describe the perceptions of general professional nurses concerning the stabilised mental health care users who had been admitted in a medical ward for medical conditions. This was the utility of Nightingale's nursing concept.

The physical environment of the MHCUs is important because their health is to be improved by rendering effective nursing care to them. It is when an optimal physical environment exists that greater attention can be given to the emotional needs of

MHCUs. The environment has a direct bearing on the prevention of complications in the diseases within the social environment of the ward. The environment in the medical unit needs to be pleasant and conducive to affecting a positive nurse-patient relationship. Therefore, the nurse remains responsible for altering the environment to improve it for the benefit of the MHCU (Selander 2010:83). All the three concepts were utilised here.

The psychological environments of MHCUs are strongly affected by the physical surroundings. The effect of the mind on the body was fairly well articulated in Nightingale's time. There was a lack of understanding of exactly how the condition of the body, as affected by the environment, could affect the mind. Nightingale recognised that a negative environment could cause physical stress, thereby affecting the MHCU's emotional climate. MHCUs need to be offered a variety of activities to keep their minds stimulated, for example playing games, attending climate meetings and, individual and group therapies. Manual activities, for instance making up of the bed, stimulate the MHCU to survive emotionally. Boredom is viewed as painful (Selander 2010:83). In the ward, communication is encouraged between nursing staff and patients. Communication should not be hurried or interrupted when speaking with the MHCU. The venue and time of communication need to be set by both the nurse and MHCU. It is important to sit down in front of the MHCU when a conversation is in process. Relatives and doctors need to communicate about mental health care users in the ward. Doctors and nurses need to encourage clarity, questions and suggestions about the condition of the MHCU. MHCUs should not be given false hopes. The social environment is related to specific data collection related to illness. The data are collected from relatives, colleagues or anyone who is capable of giving it. All three of Nightingale's concepts were utilised here.

Health is the caring of a patient in totality, physically, psychologically and socially. The three concepts need to be viewed as interrelating rather than separate. Nightingale identifies nursing as the activities that promote health. Nursing requires individuals to practise the art and science of nursing so that the nurse can be able to implement problem solving skills in a logical manner, which is known as the nursing process in modern terminology. Nightingale emphasised the need to include theoretical and clinical perceptions as part of the educational package (Selander

2010: 84). This view is shared by the results of this study. Once the nurse is in the work situation, he or she needs to apply the theoretical knowledge acquired from the educational programme as a process of integrating theory and practice.

Nursing is the protection, promotion and optimisation of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, as well as advocacy in the care of individuals, families, communities and populations (Burns *et al.* 2009: 2). This view is also applicable to MHCUs in general wards. Nightingale's nursing process consists of a four-step sequence which involves observation, identification of the need for environmental changes, implementation of the changes and identification of such current health states (Selander 2010: 86). In modern practice, the nursing process consists of seven sequential steps, namely; assessment, interpretation, planning, implementation, evaluation and documentation (Fitzpatrick & Whall 2005: 165- 169). Such an approach could be recommended for the nurses caring for stabilized mental health care users in a medical ward.

Data revealed fear related to lack of knowledge, experience and psychiatric nursing skills, lack of knowledge about psychotropic medication, and the possibility of a relapse in mental health care users. The stigma related to communication, negative attitude towards mental health care users and non-acceptance. Myths related to contagion and the perception that mental health care users are dangerous. Nurses in the medical wards need to be trained in revisiting the principles of Florence Nightingale in order to render holistic quality care to stabilized mental health users admitted in medical ward.

The researcher will disseminate the results of this study to the management of Cecilia Makiwane, at conferences, workshops and through publications in refereed journals.

4.7 CONCLUSION

The study highlighted the shortcomings of professional nurses when rendering care to stabilised mental health care users in a medical ward within a general hospital setting. Strategies and guidelines as a point of departure are to be developed for the support and education of professional nurses in order to provide effective care.

There is an essential need for professional nurses to have full understanding regarding the care of stabilised mental health care users.

It was found that, even though professional nurses may provide care to all patients in the ward, there is stigma attached to mental health care users and discrimination, although they are stable. Training should be provided for all professional nurses allocated in medical wards to empower them with skills, confidence and knowledge to care adequately for stabilised mental health care users.

There must be a further challenge for mental health professionals to become more skilled in the process of advocacy, so that the evidence presented by this study is used to maximum effect in ensuring that mental health promotion is recognised as an integral and central component of health promotion. A review of the literature provides ample evidence to conclude that primary preventive interventions can be effective for preventing psychopathology and promoting positive development, particularly in high- risk children and adolescents.

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ANNEXURE A

Certificate of Approval from the University of Fort Hare Ethics Committee



University of Fort Hare
Together in Excellence

ETHICAL CLEARANCE CERTIFICATE

Certificate Reference Number: TSH011SNKA01

Project title:	Perceptions of professional nurses regarding care of mental health care of mental health care users in a general hospital setting
Nature of Project:	Masters
Principal Researcher:	Nonkanyiso Yvonne Manona- Nkanjeni
Supervisor:	Dr DN Tshotsho
Co-supervisor:	

On behalf of the University of Fort Hare's Research Ethics Committee (UREC) I hereby give ethical approval in respect of the undertakings contained in the above-mentioned project and research instrument(s). Should any other instruments be used, these require separate authorization. The Researcher may therefore commence with the research as from the date of this certificate, using the reference number indicated above.

Please note that the UREC must be informed immediately of

- Any material change in the conditions or undertakings mentioned in the document
- Any material breaches of ethical undertakings or events that impact upon the ethical conduct of the research


The Principal Researcher must report to the UREC in the prescribed format, where applicable, annually, and at the end of the project, in respect of ethical compliance.

The UREC retains the right to

- Withdraw or amend this Ethical Clearance Certificate if
 - Any unethical principal or practices are revealed or suspected
 - Relevant information has been withheld or misrepresented
 - Regulatory changes of whatsoever nature so require
 - The conditions contained in the Certificate have not been adhered to
- Request access to any information or data at any time during the course or after completion of the project.
- In addition to the need to comply with the highest level of ethical conduct principle investigators must report back annually as an evaluation and monitoring mechanism on the progress being made by the research. Such a report must be sent to the Dean of Research's office

The Ethics Committee wished you well in your research.

Yours sincerely


Professor Gideon de Wet
Dean of Research

21 November 2013

ANNEXURE B

Letter of approval from the Eastern Cape Department of Health

L4/04/10 09:50PM

HP LASERJET FAX

p. 01



Eastern Cape Department of Health

Enquiries: Zonwabele Merile

Tel No: 040 608 0830

Date: 31st January 2014

Fax No: 043 642 1409

e-mail address: zonwabele.merile@impilo.ecprov.gov.za

Dear Mrs NY Nkanjeni 043 76111 58

Re: Perceptions of professional nurses regarding care of mental health care users in a general hospital setting

The Department of Health would like to inform you that your application for conducting a research on the abovementioned topic has been approved based on the following conditions:

1. During your study, you will follow the submitted protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health in writing.
2. You are advised to ensure, observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants.
3. The Department of Health expects you to provide a progress on your study every 3 months (from date you received this letter) in writing.
4. At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the Epidemiological Research & Surveillance Management. You may be invited to the department to come and present your research findings with your implementable recommendations.
5. Your results on the Eastern Cape will not be presented anywhere unless you have shared them with the Department of Health as indicated above.

Your compliance in this regard will be highly appreciated.

DEPUTY DIRECTOR: EPIDEMIOLOGICAL RESEARCH & SURVEILLANCE MANAGEMENT



Ikamva elilokoambileyo!

ANNEXURE C

Letter of approval from the Non Interventional Hospital Review Board

		Province of the EASTERN CAPE HEALTH
Non Interventional Hospital Review Board		
Postal Address: Frere Hospital Private bag x 9047 Amalinda East London 5200 Enquiries: B. Willie Tel: 043 709 2389		Physical Address: Frere Hospital 4 th Floor Room 4.18 Amalinda East London 5200 Email: babalwa.willie@impilo.ecprov.gov.za

14th April 2014

Mrs N. Y. Nkanjeni
Fort Hare University
Department of Nursing Sciences
East London
5201

RE: REQUEST FOR APPROVAL TO CONDUCT RESEARCH STUDY

"Perceptions of professional nurses regarding care of mental health care users in a general hospital setting."

We acknowledge receipt of the above mentioned proposal.

Having gone through your proposal, the committee has no ethical problems noted.

Please be advised that the committee has granted you the consent to do the research.

Yours sincerely


.....
Dr J. Thomas
Acting Clinical Governance ELHC

ANNEXURE D

Letter of approval from Cecilia Makiwane Hospital Medical Superintendent



EASTERN CAPE
HEALTH

Cecilia Makiwane Hospital • East London Hospital Complex • East London
Private Bag X 9047 • East London • 5200 • South Africa
Tel: 043 708 2135 • Fax: 043 760 2252 • e-Mail: siphokazi.peter@impilo.ecprov.gov.za

TO: Mrs Nkanjeni
FROM: DR L. GALO – MANAGER: MEDICAL SERVICES: CMH
SUBJECT: RE: MRS NKANJENI APPROVAL TO CONDUCT RESEARCH CMH
DATE: 30 JUNE 2014

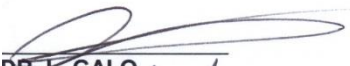
Dear Mrs Nkanjeni,

I am pleased to inform you that your request to conduct research at Cecilia Makiwane Hospital has been approved.

Please contact the Nursing Service Manager, Mrs Sixishe to make an appointment to plan your study as you are one of three other candidates approved to conduct studies amongst the nursing personnel. It would be prudent to ensure a flexible timetable. Please carry this letter when you are at the institution and interviewing staff so as to produce it when necessary.

Again thank you for considering our institution, wishing you well in your studies.

Regards


DR. L. GALO
DATE 01/07/14
MANAGER: MEDICAL SERVICES



MEDICAL SUPERINTENDENT
CECILIA MAKIWANE HOSPITAL
PRIVATE BAG X 9047 EAST LONDON 5200
DR LUNTU GALO

United in achieving quality health care for all

24 Hour call centre: 0800 000 000



ANNEXURE E

Information given to participants

339 NU 17

Mdantsane

5219

2014- 06 -04

The Participants

REQUEST FOR APPROVAL TO CONDUCT A RESEARCH STUDY

I am currently a Master's in Nursing Science degree (M Cur) student at the university of Fort Hare, East London branch. One of the requirements for this qualification is to conduct a research study in the related field. The research study that I have proposed to do is:

"Perceptions of professional nurses regarding care of mental health care users in a general hospital setting"

The main purpose of this study is to determine the perceptions of general nurses regarding care of stabilised mental health care users who are in a general hospital setting.

The significance of this study to the department may help general nurses in a medical ward to improve the care of stabilised mental health care users. Summary of findings will be made available on Denosa nursing update, workshop and symposium which will result in high total patient care.

I am hoping that this request will receive your favourable consideration.

Kind regards,

Mrs Nonkanyiso Yvonne Nkanjeni (Masters' Student).

ANNEXURE F

WRITTEN INFORMED CONSENT FOR RESEARCH PROJECT

I,....., voluntarily agree to participate in a research project of a descriptive study :Perceptions of professional nurses regarding care of mental health care users in a general hospital setting.

I understand what the project is about, as it was explained to me by the researcher and I understand that I incur no risk by participating.

I have a right to withdraw or to refrain from answering a question if I feel like doing so.

Confidentiality of the information given is ensured by anonymity and only the researcher and the supervisor will have access to the data.

I understand that there are no anticipated risks in the study.

Contact details are provided for further questions about the research project.

Contact details: Mrs N.Y. Nkanjeni - cell 082 398 4304.

Participants

Signature..... Date.....

Researcher's

Signature..... Date.....

ANNEXURE G

Interview guide

Section A: DEMOGRAPHIC DATA

Participant No:

Age:

Name of Institution:

Work experience as a professional nurse:

Section B: INTERVIEW QUESTIONS

1. What are the perceptions for general nurses not willing to render nursing care to medically ill stabilized MHCUs who are admitted for medical wards?
2. What are your views about medically ill stabilized MHCUs who are admitted to a medical ward?
3. What would you recommend as a strategy to render holistic nursing care to these patients in a medical ward?

ANNEXURE H

Key

R: researcher

P: participant

Interview 001

R: What do you think are the reasons for staff working in general ward to be unwilling to care for stabilised mental health care users (MHCUs)?

P: We are not psychiatry trained and we lack nursing skills to care for MHCUs. We often have bad attitudes when we read from notes that the patient we are admitting has a history of mental illness forgetting that they are also human beings who may suffer from any other illness.

R: Tell me more.

P: We also have lack of experience in nursing these stabilised MHCUs.

R: Ooooh elaborate.

P: I feel frightened because stabilised mental health care users are unpredictable and they are potentially dangerous. If they relapse, they will harm bedridden, helpless patients and I'll be responsible for that.

R: Do you understand that they are stabilised?

P: Although we know they are stabilised, we fear them having a relapse while they are still in our general ward. There is a misconception that mental illness is contagious.

R: How can you describe the relationship between the nursing staff and MHCUs in your ward?

P: The relationships are not good.

R: What do you mean by that?

P: Some of the MHCUs lack eye contact when we try to communicate with them. They do not have free, full conversations. They only give short replies to questions directed to them; for example, they only say yes or no with eyes closed or not even looking at the nurse. Sometimes I don't have enough time to listen to all the problems of patients in the ward as we are short-staffed. Users are attention seekers I know the. They like to be owned by all of us.

R: Is there anything else?

P: The MHCUs are usually aggressive and easily irritable. The nurses fear this so they distance themselves caring for stabilised MHCUs.

R: Oooh so this distancing causes there to be a void between the nurse and the MHCU, prohibiting relationship from developing.

P: We sometimes request the presence of security officers when we are going to perform certain procedures to MHCUs.

R: Doesn't this violate their privacy?

P: It does but we have fears. We cannot handle them on ourselves. When the security officer is present, the MHCU seems to be calm because they fear the authority present.

R: Do you do anything to encourage positive relationships with the MHCUs?

P: I smile and try to make conversation on days when the MHCUs are willing to communicate to show that I accept them as they are.

R: How do you observe that they are willing to communicate?

P: They initiate conversation in a friendly manner and try to share jokes with other patients and staff in the ward.

R: What do you think can be done to encourage general nurses in nursing stabilised MHCUs with a medical condition?

P: General nurses need to get psychiatric training.

R: How will that help them?

P: If they are trained, they will acquire skills and knowledge on how to handle stabilised MHCUs with medical condition.

R: Training takes longer. Isn't there something that can be done to help in a shorter period of time?

P: oooh (nodding head) In-service training. This is done on a weekly basis; Tuesdays between 11 and 12. It will be useful to include a psychiatric topic in the sessions. A specialist psychiatric nurse can visit the ward as per request of consultation to ask the patients questions such as how they coped when they lost a member of our families.

Interview 002

R: What do you think are the reasons for staff working in general ward to be unwilling to care for stabilised mental health care users (MHCUs)?

P: Some come here being violent, aggressive and using abusing language.

R: When they come to the general ward, do they come with their prescribed psychiatric treatment?

P: Yes.

R: Do you give them the treatment?

P: Yes, because we check the in-patient prescription chart.

R: Do you check or observe any of the extra pyramidal side effects of the psychiatric treatment?

P: There is no report of presence of side effects from the MHCUs.

R: How can you describe the relationship between the nursing staff and MHCUs in your ward?

P: The relationship is poor.

R: oooh explain.

P: Most of us, we have fears to care for stabilised MHCUs. Sometimes, when the stabilised MHCUs get aggressive, the nurses run away.

R: What do you think about the safety of other patients who are bed-ridden when you run away?

P: I think of that when I have already run away. You first think about your own safety before you think of others'. When I realise what has happened, I call for help. Psychiatric nurses are always willing to come help us.

R: Anything else?

P: I often find myself saying, "Every time you request some more from the food, you're not the only patient in this ward."

R: What do you think can be done to encourage general nurses in nursing stabilised MHCUs with a medical condition?

P: It is important not to be loud when you talk to the stabilised MHCUs. That way, you do not provoke them. They must be treated with dignity, as the other patients are. It is wise to educate subordinates not to overreact when dealing with MHCUs.

R: Anything else?

P: There should be a medical ward within the psychiatry department so that they can be admitted and cared for by psychiatric nurses when they have medical conditions (showing strong feelings about the topic). When they are in general medical wards, they disrupt the ward and make other patients uncomfortable.

R: Hmmmm

P: I understand that psychiatric nurses get danger allowance; it would be an incentive to offer general nurses as they care for stabilised MHCUs in the general ward.

Interview 003

R: What do you think are the reasons for staff working in general ward to be unwilling to care for stabilised mental health care users (MHCUs)?

P: Not knowing the cause of patient to behave strangely makes me feel uncomfortable. They come to the ward violent. They insult nurses, using vulgar language. There is also a stigma attached to mental illness because even if you have not done anything wrong, you will be labelled with bad names.

R: They insult nurses (restating).

P: Also, some of the nurses are psychiatric trained but they lack the practical skills as they were not allocate in a psychiatric department.

R: (nods head to show interest) Go on.

P: We do not know what to do when they are restless. In our ward, there are three courtside beds. If they are occupied, we restrain the MHCU in a normal bed. This causes misunderstandings between the nurses and relatives when they visit their family member and find them restrained. We find it better to control the MHCUs when they are restrained.

R: What do you do?

P: We explain the situation to the relatives.

R: According to the Mental Health Care Act, we are not allowed to restrain MHCUs.

P: Oooh I didn't know that.

R: Is there anything else you do?

P: If they are in a normal bed, restrained, we have to observe them and also ask for the presence of security officers to ensure the safety of the nursing staff and other patients as they sometimes manage to loosen their restraints. Some also jump out of their courtside beds when they succeed in loosening their restraints.

R: Any other reasons?

P: We are also reluctant to nurse them because we never feel safe. Another thing, we do not qualify for danger allowance because our department is not a speciality unit.

R: How can you describe the relationship between the nursing staff and MHCUs in your ward?

P: We care for them as we do other patients. We do not have an attitude towards them.

R: Ooooh meaning that your relationships are good?

P: Yes. They also do not show an attitude towards us.

R: What do you think can be done to encourage general nurses in nursing stabilised MHCUs with a medical condition?

P: I think we must be motivated.

R: How?

P: By getting incentives, for example, danger allowance just like psychiatric nurses because our lives are in danger as the MHCUs are unpredictable. I've been getting in service education on what to look for in stabilised mental health care users and how to take assessment data during admission period. I felt a bit more confident in assessing them. Initially, I wasn't comfortable but the more information I've got makes me feel much better.

Interview 004

R: What do you think are the reasons for staff working in general ward to be unwilling to care for stabilised mental health care users (MHCUs)?

P: We fear them. We are not safe to nurse stabilised mental health care users as mental illness is contagious. One can acquire it by nursing mental health care users. Institutions for mental illness were built in isolation. I think the motive behind was that patients were not supposed to be nursed with the other diseases.

R: Why do you have fears with MHCUs?

P: When they have aggression, they beat us; as a result, we run out of the ward - leaving the bed-ridden patients at risk. Some patients are admitted without having given history of their psychiatric condition, compromising the safety of nurses. Speaking from experience, we once admitted a patient unaware that he was a MHCU, given false history by his father that the patient is only epileptic. In the early hours of the morning, the MHCU attacked another patient without any apparent reason. After that, he became aggressive and destructive. He broke window panes and physically assaulted nurses. I managed to phone the security officers and seven of them came to assist us.

R: So you do not want to help them because of this experience?

P: Yes. Other patients also become uncomfortable in the ward because of the unrest. We also have a shortage of staff, especially male staff. At the present moment, there are only three

female nurses per team, attending to 40 patients. There are no security officers allocated to our ward.

R: How can you describe the relationship between the nursing staff and MHCUs in your ward?

P: There are poor relationships because of the fears we have.

R: Do you try to build relationships with them?

P: We are not willing to build relationships because they are unpredictable, sign and symptoms of aggression develop in the ward because they are in an unfamiliar environment. I just ignore the mental health care users when communicating, trying to report about funny symptoms they observe from themselves sometime to me as they like most of the time to be spent with them while the ward is full and I'm rushing to finish medication. Sometimes I think that I will come back to listen to the problem but forget and think about it when I'm at home. I even don't have time to look for clean pyjamas if the patient has requested a change. With others, we build a nurse-patient relationship at time of admittance.

R: Why do you build relationships with them, how?

P: Because they show no signs of a mental condition and when asked questions, they give relevant answers.

R: So you build your relationships on a discriminatory system? MHCUs need to be loved, accepted and praised. If you tried this with those MHCUs who are admitted showing sign of their mental condition at the onset, you would build trusting relationships with them. Caring for them would become easier.

R: What do you think can be done to encourage general nurses in nursing stabilised MHCUs with a medical condition?

P: It would be better if we got remunerated for practising skills out of our qualifications.

R: Anything else?

P: We need enough staff on duty, especially male nurses in a male medical ward. The presence of a male figure tames MHCUs. We also need seclusion rooms to isolate aggressive patients as they are dangerous to themselves, nursing staff and other patients. I think the

psychiatric department needs to have its own medical ward to care for stabilised MHCUs with medical conditions. We also need to develop skills on how to handle them through in-service training, to also know different type of drugs to administer to aggressive MHCUs.

Interview 005

R: What do you think are the reasons for staff working in general ward to be unwilling to care for stabilised mental health care users (MHCUs)?

P: Some do not have qualifications to care for MHCUs.

R: How will a qualification help the staff?

P: We will have knowledge of how to handle stabilised MHCUs.

R: Go on (nodding head).

P: The infrastructure is not suitable for caring for MHCUs.

R: What do you mean?

P: We do not have seclusion room like the mental health department does; our doors are always open, making it possible for the restless ones to exit, this making them vulnerable to more dangerous situations as our hospital is under construction.

R: Is there any other reason?

P: When the patients come here, staff is not given a full history by their family members that they have a psychiatric illness and they are on treatment. We also find it difficult to administer psychiatric treatment, as we are unfamiliar with it. We need to be accurate if patients are on psychiatric treatment. Some of their treatment has extra pyramidal side effects, causing the MHCUs to get negative attention from other patients. When the MHCUs get this attention, they become uncomfortable, causing them to be aggressive.

R: How can you describe the relationship between the nursing staff and MHCUs in your ward?

P: The relationships are poor because of the fears we have. We are used to caring for patients with medical conditions only.

R: Do you understand that, in nursing, you must care for a patient in totality?

P: Yes; mentally, physically, spiritually and socially.

R: But you ignore the mentally.

P: Yes because of their bizarre behaviour, which we are unfamiliar with. They enjoy their own company.

R: When the patient displays this bizarre, what do you do?

P: Mmmm, keep my distance. Yes probably not the best treatment for them, but... Well, it's my way of coping. It's an avoidance issue.

R: How?

P: Some laugh inappropriately, talk to themselves and have visual and/or auditory hallucinations. These cause us to withdraw ourselves from them.

R: What do you think can be done to encourage general nurses in nursing stabilised MHCUs with a medical condition?

R: In-service training on how to treat and manage psychiatric patients. Psychiatrists should visit the medical ward on a daily basis to check the condition of stabilised MHCUs. Danger allowance would also encourage us to care for the patients because of the risk we face. We also need to hold quality circle meetings with both the medical and psychiatric staff where we would discuss burning issues.

Interview 006

R: What do you think are the reasons for staff working in general ward to be unwilling to care for stabilised mental health care users (MHCUs)?

P: We do not have the same drugs which are used by the psychiatrists to calm aggressive patients. We stock one or two drugs, but these are the less effective ones. Patients are labelled and staff take this on and do not look beyond it. Mental health care users coming into hospital are sometimes just labelled as confused. If this schizo brought in treatment from home, we need to confirm with doctor that it is the right treatment. We also request family members to bring their clinic book the next day. The patient will say, "Sister, please give me the small yellow tablets or injections because I am seeing everything double." It is difficult to issue the

psychiatric treatment to bipolar patients because I don't even know the names, colour and shapes of the tablets.

R: You were told that a stabilised mental health care user is coming for admission in your ward. How did you feel?

P: I felt overwhelmed because when such patients are admitted in the ward, treatment administration period is delayed because it takes time to search for their treatment in the medication trolley as we are unfamiliar with their treatment. We also lack knowledge on how to deal with stabilised MHCUs. We don't get incentives like psychiatric nurses do. The nursing staff has fears to care for the MHCUs as some believe that the condition is contagious.

R: Can you tell me about the environment?

P: The environment is not conducive to care for stabilised MHCUs.

R: What do you mean?

P: There are no areas for in-door games, or to hold therapy sessions. I understand that in the psychiatry department there are occupational therapists. These therapists group the MHCUs according to their capabilities like drawing, hand work, making of beds to boost self-esteem and to improve personal well-being.

R: How can you describe the relationship between the nursing staff and MHCUs in your ward?

P: Poor.

R: How?

P: In the medical department, there is a shortage of staff and patients are bed-ridden; they need to be fed and changed positions. MHCUs need more attention and they want to own their nurses. This is not possible because we are busy and our priority is the medical condition, not the mental condition. MHCUs demand a lot, requesting things like tobacco and more food stating that their treatment makes them hungry. We refuse them these.

R: Oh so that makes you unapproachable next time, causing your relationships to be poorer.

R: What do you think can be done to encourage general nurses in nursing stabilised MHCUs with a medical condition?

P: We want danger allowance and we could undergo training to acquire more skills. The more information we have got about mental illness will make us feel a lot better.

Interview 007

R: What do you think are the reasons for staff working in general ward to be unwilling to care for stabilised mental health care users (MHCUs)?

P: We are not psychiatry trained. We do not have experience in caring for the MHCUs and we lack communication skills. We have no insight in mental health illness. Also, we struggle to notify the doctor and sometimes the doctor taking time to respond to your call is frustrating. Mental illness has a lot of stigma attached to it; people do not understand the mental illness. Patients present with physical needs but often have mental health problems masked by physical symptoms. Once the stabilised mental health care user suffers from hallucinations, sometimes he becomes destructive; just tears notices hung on the wall and pushes pot plants. This causes fear.

R: How can you describe the relationship between the nursing staff and MHCUs in your ward?

P: We treat them just like medical patients. There is no favouritism.

R: What do you think can be done to encourage general nurses in nursing stabilised MHCUs with a medical condition?

P: We need to have in-service training, to attend short courses and workshops. We also need to hold climate meetings between medical and psychiatric staff. I think sometimes it is right to admit stabilised mental health care users in medical ward so that they can see and feel that they are accepted by other nurses in the hospital. The drugs that the patients are on are not suitable and our doctors don't have much idea. Doctors, as well as nurses, need to be educated.

ANNEXURE I

Letter from the editor

Hester Honey
91 Brandwacht Street
Stellenbosch 7600

12 December 2014

Declaration re Language Editing and Technical Care

I, Hester Honey, hereby declare that I have examined

**THE INVESTIGATION OF PERCEPTIONS OF PROFESSIONAL NURSES
REGARDING CARE OF MENTAL HEALTH CARE USERS IN A GENERAL
HOSPITAL SETTING**

By

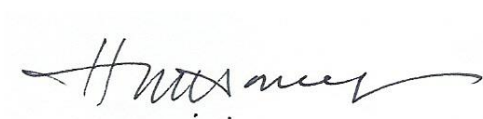
NONKANYISO YVONNE MANONA-NKANJENI

STUDENT No. 8700664

(A thesis submitted in fulfilment of the requirements for the degree of M.CURATIONIS (Psychiatric Nursing) in the School of Health Sciences at the University of Fort Hare)

and have suggested adaptations regarding language use to be implemented by her.

Yours sincerely,



12 December 2014