THE NEWLY QUALIFIED PROFESSIONAL NURSES' PROFICIENCY IN UTILIZING PSYCHIATRIC NURSING SKILLS IN MENTAL HEALTH INSTITUTION AND COMMUNITY HEALTH CARE FACILITIES.

BY

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A mini – dissertation submitted in fulfillment of the requirements for the Master’s Degree of Nursing Science (Magister Curationis) by course work and mini – dissertation

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SUPERVISORS STATEMENT

This is to certify that this study was conducted by Lulama Henrietta Zonke.

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Under our supervision.

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DECLARATION

I declare that this study is the product of my own work and where I have used the ideas and words of others, I have referenced these correctly.

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L. H. Zonke 17.04.2012
DEDICATION

This dissertation is dedicated to:

The Lord Almighty, Who makes things possible in life.

My beloved boys Lwando Mhlangabezi Zonke, Lunga Anele Zonke and my first grandchild Zenande Onesime – sihle Zonke.
I would like to express my gratitude to the following people for helping me to finally achieve my goal.

First and foremost, to the Lord Almighty. Father God, You have never left me nor forsaken me and for that I will always praise Your Holly Name. “Surely His Goodness and Mercy shall follow me all the days of my life and I will dwell in the house of the Lord forever” (Psalms 23 ves 6).

To my late parents, who valued education so much. I will always appreciate the love and support that you gave me throughout my education (Enkosi Gasela no Mandlovu).

To Mrs Magadla, for your patience throughout this mini – dissertation, you were not just a supervisor but a mother, a sister and a friend. I would like to also thank Mr Magadla who would allow me to utilize their spare time, and always involve him in my work. Thank you Radebe and Magasela.

To friends and family who were always supportive financially and otherwise during my studies, thank you.
ABSTRACT:

The aim of this study was to determine the ability and proficiency of the newly qualified professional nurses in utilising psychiatric nursing skills at Chris Hani District Psychiatric Health Care Services in the Eastern Cape, South Africa.

The research method was a qualitative, phenomenological approach. A purposive sample of newly qualified professional nurses and supervisors participated in the study. The data were collected through interviews and focus group discussions, using semi–structured interview guides. Interviews responses were recorded on the interview guide. Data were analysed using the computer software Atlas ti and manually. Positive and negative themes were identified. Ethical considerations were ensured by means of privacy, anonymity and confidentiality. Ethical clearance was obtained from the University of Fort Hare and permission from the Provincial Department of Health and Chris Hani District Health and Mental Health Institution at Queenstown was sought.

The findings revealed that newly qualified professional nurses performed well, according to the perception of their supervisors. Newly qualified professional nurses were faced with challenges such as shortage of resources, mental illness not considered as a priority and lack of skills development. The study also revealed that newly qualified professional nurses focussed on the curative aspect of ailments, rather than preventive care. However community health workers (CHW) focussed on the preventive aspect of care.

Limitations and recommendations based on the findings of the study are presented.
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CHAPTER 1: Introduction and background

1.1 Introduction:

This study is about the evaluation of the clinical performance of newly qualified psychiatric professional nurses. To render quality care, nurses need sufficient exposure to clinical learning. Different problems need different interventions because these problems manifest differently. Among these, mental illness, impacts negatively on the lives of the sufferers and their families as it tends to be chronic. This demands committed and knowledgeable psychiatric practitioners, who can cope with the burden to families caused by de-institutionalisation during the recent years (Uys and Middleton, 2004: 77).

All professional nurses, including newly qualified psychiatric nurses, undergo training to obtain skills that will enable them to render efficient services to users, families, and communities. They undergo integrated training that is the four year comprehensive course, which is regulated by the South African Nursing Council (SANC), under regulation leading to approval as a professional nurse. This is based on minimum requirements for the education and training of a nurse (general, psychiatric and community) and midwifery leading to registration as a professional nurse (SANC, 1985). At first level, the introduction to psychiatric nursing, which is worth two credits, is offered and it embraces the psychiatric terms, history of psychiatry, philosophy of life, health education, communication and therapeutic use of self.

In the Eastern Cape Nursing College, the psychiatric content is pursued at third level (Psychiatric Nursing 1, PNS 1) with 22 credits. The PNS1 content covers terminology, prevention of mental illness, classification of mental illness, psychopathology and the Mental Health Care Act, 2002 (Act 17 of 2002).

At fourth year level, learners embark on psychiatric nursing science two (PNS 2) which carries 24 credits and whose content is: childhood and adolescent disorders, community psychiatry, forensic psychiatry, legislation, psycho- geriatrics and the nursing process.
The above content is expected to produce a professional nurse with appropriate competencies. The SANC has stipulated the competences for professional nurses who are prepared under regulation R425 (SANC, 1985) as follows:

- The newly qualified psychiatric nurse is empowered to conduct mental health education to users, families and community on the following:
  - Mental health disorders, factors predisposing to mental illness, importance of compliance to medication, prevention of mental illness, mental health promotion, side effects of medication and the management of such.
  - The newly qualified psychiatric nurse should be able to conduct mental status examination, supportive interviews, ward climate meeting, group therapies, group activities and the stimulation of intellectually disabled users. The newly qualified psychiatric nurse should possess competences stated above which correlate with community demands, contemporary trends, budget and social change including human trafficking and sexual disorders (Rassaaq, Omolola, and Oladoyin, 2004: 50). Operationalization of the competences is rooted in factors like professional solidarity, accountability and strict adherence to a professional code of ethics (Melish, Brink and Paton, 2006: 84). The above mentioned statement is supported by SANC (2004) who emphasize the maintenance of standards to ensure safe patient care.

When doing practical, students are part of a multidisciplinary team (MDT) as they have to perform procedures like: admission and discharge, mental status examination of patients, administering and monitoring of medications to patients, conducting health education, promotion of good mental health care that is hygiene and nutritional status, conducting pre discharge education and involving family members. SANC (1985) allege that the student shall function as a member of the health team with certain responsibilities for patient care from commencement of her / his training. As part of the MDT, the learner is expected to conduct outreach programmes like educational campaigns to communities and schools to de-stigmatise mental illness and to conduct awareness campaigns about predisposing factors to mental illness (Uys and Middleton, 2004: 85).
Throughout her practice, the newly qualified psychiatric nurse conducts the above mentioned activities which are embraced in psychiatric interpersonal skills. Background information was conducted to obtain the correlation of practice with theory by newly qualified professional nurse, considering the demands of the patients and the community priorities. The background information elicited the status quo regarding the newly qualified professional nurse.

1.2 Background of the study:

Seeing mental health care users roaming around in the street is a common occurrence in Queenstown and surrounding areas. Some of these users feed from the refuse bins. Also, observing groups of youngsters idling around aimlessly, raises concern, because one often picks up the smell of dagga whenever these groups are seen. Dagga is one of the abused substances and is related to mental illness, however this can be avoided through awareness campaigns as depicted in the curriculum. One may question whether awareness campaigns do actually take place.

According to section 20 (1) of the Mental Health Care Act (Act 17 of 2002), it is required that a mental health care user may be transferred from inpatient to outpatient care. This means that patients can be nursed in their communities. When negative reports are given / issued about the status quo of patients, who is further committing unacceptable acts and crimes as well as those roaming around with unkempt appearances, it reflects unacceptable standards of care. The researcher is of the opinion that education of users, families and the community is not carried out effectively.

It is questionable if families are empowered to care for mentally ill users, yet Uys and Middleton (2004: 77) allege that families have been observed to play a major role in the care of the mentally ill users. The beliefs of society about mental illness are significant because society does not always regard mental illness as simply another illness in black culture, but is associated with an affliction that needs cultural intervention by traditional healers (Uys and Middleton, 2004:78).

Traditional myths require nurses to conduct educational campaigns, to create awareness about the condition and to create a balance between scientific and
traditional medicine. Failure of the nurse to create awareness in relation to medication can enhance relapse (Uys and Middleton, 2004: 78).

Olfson, Mechanic, Hansell, Boyer, Walkup and Weiden (2000: 29) found that 73.7% of mental health care users are readmissions and 62% of the total group were actively receiving treatment when they were admitted; this relatively high compliance with medication could not be confirmed objectively. Therefore involvement of family in the care, treatment and rehabilitation of patients is of prime importance, and needs to be enforced by nurses. Nurses should conduct home visits as a follow up, so as to identify compliance to treatment by users.

It is imperative to evaluate the new practising professional nurse in terms of her knowledge application. In particular, the researcher will view the status quo of the new professional nurse namely those who qualified in 2005 – 2009, based on the following: when the curriculum was last reviewed, aspects that might need to be changed in the curriculum, as well as the community disease profile. The situation of the new professional nurse needs attention regarding the following: Family crisis, child abuse, human trafficking and clinical teaching role to determine the extent to which she can apply the psychiatric skills. From the above background, the researcher will outline the research problem.

1.3 Problem statement:

Discharged users are cared for by the psychiatric primary health care nurse in the community. It should be mentioned that the psychiatric professional nurses currently at the psychiatric community services are the newly qualified. The psychiatric nurse at the psychiatric services in both hospital and community requires psychiatric interpersonal skills to be used in making observations, making assessments for mental status, anxiety levels, intensity of the problem, family health, interviewing, counselling individuals / groups and crisis incidents to mention some. The researcher is concerned about the services provided to the families of the users. It is questionable if the new psychiatric professional nurse is prepared to respond effectively to psychiatric community health demands. This concern is founded on the following:
Clinic records have shown constant visits to the clinic by the same users, resultant to long queues. Records have also shown that the same users were re admitted more than once. This could be a sign of lack of health education skills to the users and the families. It should be indicated that even if the newly qualified psychiatric nurse has skills, it would be hard to apply the skills as there are times where the newly qualified psychiatric nurse has to manage two wards in designated mental health institutions, as applicable to hospital setting. Whilst the professional nurse is in one ward, the other ward remains with nursing assistant and student nurses, if they are allocated in that particular month. It should be considered that because of staff shortage, the student nurse does not get any mentoring or couching. The same thing could have happened to the current psychiatric professional nurse. The above mentioned concern has been cited by SANC (1990) when they argue that student nurses are not exposed to clinical learning in a satisfactory manner.

The nagging question in the mind of the researcher is about the ability of the professional nurse to prepare users and families for discharge and render the interpersonal skills as mentioned above to the community members, given the shortage of personnel and the long queues of patients.

Regarding the referral system, it is questionable as to whether primary health care nurses are informed when a patient is discharged, so as to follow up and to monitor compliance.

Given the problems shown above, a study should be conducted.

**1.4 Purpose and objective of the study:**

To determine and describe the ability and proficiency of newly qualified professional nurses in utilising psychiatric nursing skills in hospital and community health facilities.

**Research Objective:**

The objective of this study is to:
Explore and describe the ability to produce psychiatric nursing skills by the newly qualified professional nurses at the Chris Hani District Psychiatric Health Care Services in execution of tasks as stipulated in the competencies.

1.5 Research question:

1. How do the newly qualified psychiatric professional nurses’ describe their experiences and their proficiency in utilising psychiatric nursing skills in a hospital setting and a community health care facility?

2. What are the experiences of supervisors of newly qualified psychiatric professional nurses in terms of the competency and proficiency skills they observe in the newly qualified professional nurse?

This study will therefore address the above questions.

1.6 Significance of the study:

The recommendations from this study will be used to improve the effectiveness of the newly qualified professional nurses in mental health service delivery and to add whatever is necessary in the curriculum.

1.7 Definition of concepts:

Professional nurse:

Mellish et al (2006: 7) states that “a professional nurse is a qualified person who prepared over a long period by a specialised form of education at a recognised educational institution, and her licensure to practise follows on examination before being registered with the approved registered body”.

Hawker and Waite (2007:720) cite that a professional is a skilful, competent and polished person.

Newly qualified professional nurse:
In this study, a newly qualified professional nurse refers to a four year comprehensive trained nurse who has been trained in psychiatric nursing technics and who qualified between 2005 and 2009.

Proficiency:

It is the ability or skill to perform (Trumble, Stevenson and Soanes, 2007: 772).

Community health facility:

It is a place where services are directed to meet the health needs of groups or community members (Stanhope and Lancaster, 2000: 991).

Psychiatric nursing / Psychiatric nursing skills:

It is an interpersonal process in which counselling is aimed at supporting and facilitating healthy life style functioning (Uys and Middleton, 2004: 15)

Clinical teaching:

It relates to teaching of students in a clinical setting, where patients are examined and treated for their illnesses (Wehmeier, McIntosh and Turnbull, 2005: 264)

1.8 Design

It is a qualitative, descriptive, exploratory and contextual study with phenomenological approach. Botma, Greeff, Mulaudzi and Wright (2010: 190) define phenomenology as a means for describing the experiences of the participant.

1.9. Research Method

Population:

Population is formed by supervisors of newly qualified psychiatric professional nurses and the newly qualified psychiatric professional nurses working at the mental institution and two clinics at the Lukhanji Local Service Area.

Sample and sampling:
Sample will be purposive that is specific to newly qualified psychiatric professional nurses and their supervisors. The number of supervisors and newly qualified psychiatric nurses in the sample (sample size) will be determined by the saturation of data.

**Inclusion criteria:**

All the newly qualified psychiatric professional nurses who qualified between 2005 and 2009, who work at the mental institution and in any of the two selected clinics as well as supervisors in the settings given above.

**Exclusion criteria:**

Professional nurses who were not in any of the selected settings, with more than five years practical experience as well as their supervisors, were not part of the study.

**1.10. Ethical consideration:**

As research is an ethical activity, the researcher is bound to conduct research in an ethical manner that will not violate human rights. Brink (2009: 30) states that “failure to conduct research in an ethically accepted manner undermines the scientific processes and may have negative consequences”. Ethical clearance was sought and obtained from the University of Fort Hare where the research ethics committee confirmed the suitability and the standard of the research to be conducted. Permission to conduct the research was obtained from the provincial research unit at Bhisho and from the Chris Hani District Mental Health authorities. The above is advocated by Botma et al (2010: 12) who indicates that permission should be obtained from the authorities in charge of the area in which the research is to be conducted.

Full information about the objectives and activities of the study was explained to prospective participants. The dignity and respect of the participants was maintained at all times in the manner of communicating with them; privacy and confidentiality were ensured. Circumstances surrounding withdrawal from the study were explained. The researcher assured the participants of no harm. The participants were informed that if anyone felt like withdrawing from the study, such a person could do so without being intimidated.
Written and informed consent was secured from those who were willing to participate in the study. The researcher would allow the participants to have freedom to conduct the study with autonomy without any external controls, coercion and exploitation. All of the above principles were ensured when the study was conducted.

1.11. Overview of the study:

An introduction to the study was given and the background of the study was elicited. The problem statement was elicited from the background. The purpose and objective of the study was given. The research question which is correlated with the objective has been given.

Two unstructured interview guides namely one for the supervisors of, and the other for the newly qualified psychiatric professional nurses. Interviews were conducted to newly qualify professional nurses and their supervisors.

1.12. Conclusion:

From the above, the researcher was convinced of the need to conduct the study and the outline of the budget was prepared to get financial assistance. The researcher conducted some literature search so as to obtain some insight of the problem being researched by viewing the studies previously conducted.
CHAPTER 2:

2. Literature review

2.1 Introduction:

Concern about inadequacy in clinical teaching / learning seems to exist and has been expressed by several researchers including the South African Nursing Council (SANC, 1990) during college and hospital inspections. Mellish et al (2006: 198) also cite that effectiveness of training courses have not been explored in a satisfactory manner; which may be due to variations in differing assessment tools. Student nurses are allocated in clinical areas as part of a nursing team in order to gain clinical learning experience. The nursing profession mainly meets the needs of people, hence as health changes, so too must health care (Nursing Update, 2011: 22). The clinical learning experience is described as the heart of professional education, as it provides students with the opportunity to consolidate knowledge, socialise into professional roles and acquire professional values (Mellish et al, 2006: 200). SANC (2004) alleges that most nursing students mention a lack of clinical learning / teaching as the major factor causing stress. Considerations such as these have served as the basis for the present study.

SANC (1990) stated that the registered nurse does not apply frequently her theoretical knowledge of nursing in practice, and that student learning in the wards is inadequate. It is still not clear how the ward staff interact with nursing students in clinical areas as well as with their colleagues as a means of staff development. The high rate of readmissions or of patients wondering around the streets of Queenstown, raises concerns regarding the programmes of care rendered in institutions and the performance of newly qualified professional nurses is questioned, since they are the ones mostly manning the hospital wards and facilities. Ramlagan, Pelzer, and Matseke (2010: 40) state that in South Africa, alcohol and drug abuse was highlighted by former president Nelson Mandela in his opening address to Parliament in 1994, as a problem that needed attention among the social pathologies. The newly qualified psychiatric professional nurse is expected to
demonstrate proficiency with regard to the above mentioned statements. The literature will focus on the following:

- Status quo of mental health service delivery
- Disease Profile
- Programmes for nurse preparation
- Family violence and child abuse in all forms
- Human trafficking
- Review of the curriculum

2.2 Areas of concern:

2.2.1 The status quo of mental health service delivery:

Patients roaming around the streets of Queenstown area, unkempt and feeding out of refuse bins, raises concerns. Teenagers that are in groups, especially boys abusing substances, also increase the predisposing factors to mental illness. De-institutionalisation is not effective, regarding the high readmission rate (Olfson et al, 2000: 24). They stated that 73.7% are readmissions and 62% of the total group were actively taking medication when they were readmitted but the reason for this relatively high compliance with medication could not be confirmed objectively. It is questionable if the educational campaigns in communities are effective, if conducted at all.

The skill that is required here is discharge preparation for the users and health education to family and the community. This is where the interpersonal skills and the awareness campaigns by a psychiatric nurse are significant and health education to communities to prevent stigma attached to mental illness (Uys and Middleton, 2004: 75).

2.2.2 Disease profile:

It has been observed by the researcher that some of the patients, who are at Komani Hospital, are there because of substance abuse induced behaviour. The overall disease profile comprises mainly psychosis, bipolar mood disorders, stressful life events
and schizophrenia (hospital statistics, 2010). Within the disease profile, compounding factors need to be indicated namely cultural, social attitudes and beliefs are speculated as common reasons for non-adherence to medication (Kazadi, Moosa and Jeena, 2008: 53). Substance abuse which has been mentioned in the disease profile as well as stressful life events due to homelessness and poverty require combating skills which revolve around the proficiency of the newly qualified psychiatric professional nurse.

Though there were a few sufferers of depressive disorders, the above mentioned disorders dominated. These conditions can be controlled with proper management, family and community involvement. Also, if educational campaigns are conducted to increase awareness and reduce predisposing factors to mental illness, the impact of mental illness can be alleviated. Nowadays, there is so much cultural diversity. If nurses do not understand their client’s customs, ethnic issues, and languages, decrease quality of care and poor health outcomes can result. The researcher has observed that most people diagnosed with HIV and AIDS, tend to suffer from psychosis, which may indicate that, amongst others, the individuals do not accept their positive status. Others get depressed due to the fear of the stigma attached to HIV and AIDS and the psychiatric manifestations associated with this infection (Uys and Middleton, 2004: 482). They tend to be depressed and as such, need be protected from committing suicide and therefore need close supervision. It is essential then for the professional nurse to be broad minded when dealing with mental health problems, so as to predict, plan, educate and intervene in families. The researcher is thus keen to conduct this study so as to identify deficits and plan towards the resolution of the problem (Uys and Middleton, 2004: 484).

2.2.3 Programmes for nurse preparation:

Student nurses learn theory and correlate with practice so as to develop skills. Their exposure to clinical area is minimal and faced with challenges. Some of the challenges facing the preparation of the nurse are that the nurse cannot be exposed in all the situations like violence, forms of abuse, disasters and crisis to name a few, due to their non-availability at the time. It is thus essential that a nurse is able to articulate learning obtained. Students must be educated to be educators of mental health care users and families so as to reduce incidence of mental illness. The working force mainly in
institutions is currently the product of the four year comprehensive course. The document sent by SANC (2004) states that student learning in the wards is inadequate. This poses a problem since the learner such as nursing students should have models from which to learn desirable nursing behaviour. This is not likely given the shortage of staff in the wards.

The new professional nurse faces great challenge if the educational role by the professional nurses is no longer practised (SANC, 2004). Time for student –professional nurse allocation is not enough so as to build on the student’s skills. The newly qualified psychiatric professional is a victim of this teaching-learning time deficit.

2.2.4 Family violence and child abuse in all forms:

The layout of the curriculum in nurse preparation is lacking in this aspect. Theory on violence is taught but practical exposure to violence is a by chance phenomenon.

Women and children suffer various forms of abuse because of gender and age disparities which predispose them to various abuses (Lewis and Uys, 2004: 4). Some strides to reverse this injustice have been taken in some countries and particularly in our country but the reality is that the battle is far from being won.

2.2.5 Human trafficking:

This is a new concept in which human beings including children, are stolen or kidnapped and is psychopathological in nature. It demands attention from mental health care providers. Like all psychosocial issues, it causes mental instability, through insecurity and lack of trust. In developing children, it may cultivate negative roots (Suzuki, Yasumura and Fukao, 2008: 37). Nurses should be able to intervene in the above mentioned situations.

2.2.6 Review of the curriculum:

Mellish et al (2006: 83) cite that curricula are constantly under review and that changes cannot be made too frequently since all regulations made by the SANC have to be promulgated in the Government Gazette by the Minister of Health. Therefore frequent
changes would be impracticable. This implies that the curriculum can be implemented for some time despite its deficits.

2.3 The skills to which the newly qualified nurse should be competent:

Interpersonal skills: these are psychiatric skills developing and maintaining trust, acceptance of users and their families, advocacy, broadmindedness, openness and communication enhancement.

Trust:

Nurses will be able to be trusted by users and families if they show respect and see people as human beings.

Acceptance:

Users should be accepted unconditionally, irrespective of race, education and social status.

Advocacy:

The psychiatric nurse should advocate for the users and their families. It is the nurse that should make other members of the MDT to see the plight of the users (Newell, Gournay and Goldberg, 2000: 91).

Broadmindedness:

The psychiatric nurse must remember that behaviour has a meaning and reason with this attitude; the nurse will not judge the user (Rollnick, Mason and Butler, 2005:193).

Openness:

For the user to be open, the nurse must be open. The user must be given full information regarding the health service as well as the expectations from the users.

Communication:
It is essential that the nurse communicates explicitly. Verbal and non-verbal messages should be congruent. Otherwise the patient gets confused (Newell, Gournay and Goldberg, 2000: 91).

2.4 Conclusion:

Appropriate preparation of mental health professional nurses is one of the aspects that develop a healthy foundation in mental health practice. Having established that, enhancement does not happen by itself, all students should be trained and mentored (Mellish et al, 2006: 83). The researcher believes that further research like this one should be conducted to ascertain the impact of training courses on actual performance in health care services.
CHAPTER 3

3. Methodology

3.1 Introduction:

To achieve the objective of the study, the researcher had to select an appropriate method that would generate the required data. Brink, Van Der Walt and Van Rensburg (2006:22) describe methodology as the particular way of knowing about the reality. The researcher selected the research method and determined the design of the study.

3.2 Purpose of the study:

The research aim gave a broad indication of what the researcher wished to achieve in the research. Botma et al (2010: 185) allege that the research questions usually lead from the problem statement which logically generate the research aim. The aim of this study is to determine the ability and proficiency of newly qualified professional nurses in utilising psychiatric nursing skills in psychiatric care services.

3.3 Research objective:

The objective of this study is to:

Explore and describe the ability to apply psychiatric nursing skills by the newly qualified professional nurses at the Chris Hani District Psychiatric Health Care Services in execution of tasks as stipulated in the competencies.

3.4 Research questions:

3.1 What are the experiences of the newly qualified professional nurses regarding competency and proficiency in utilising psychiatric nursing skills in a hospital and clinic setting?

3.2 What are the experiences of supervisors of newly qualified psychiatric professional nurses regarding the observed competency and proficiency of newly qualified psychiatric professional nurses?
This study therefore addressed the above questions.

3.5 Research methodology:

The description of the design that was used appears below.

3.5.1 Research Design:

The qualitative, explorative, descriptive and contextual design was used. Qualitative research is described as focusing on qualitative aspects of meaning, experience and understanding (Brink, 2006: 113). The researcher conducted interviews to explore and describe the lived experiences of the newly qualified professional nurses as well as the observations of supervisors regarding the skills of the newly qualified psychiatric nurses.

Explorative design was used in this study, as the researcher wanted to get information on how the newly qualified professional nurses’ competencies and proficiencies were, in utilising the psychiatric nursing skills in mental health institution and community health care facilities, by interviewing them as well as their supervisors.

Descriptive design was used to describe the competencies and proficiencies of newly qualified psychiatric professional nurses as they, together with their supervisors perceive them. Descriptive design is defined as a non-experimental design used if the researcher wants to describe the variable of interest (Botma et al, 2010: 110). The advantages of descriptive design are that they are relatively inexpensive and take less time to conduct. The variable of importance in this study is the ability and proficiency of newly qualified professional nurses in utilising psychiatric nursing skills and the observations of their supervisors on such.

Contextual design: The context of the study was formed by use of the concepts that are used to propel the study forward. Theoretical framework was based on the modification of the communication process by Donovan cited by Kerr, Weitkunat and Moretti (2005: 208). This model was selected because it is inclined towards the roles of the newly qualified psychiatric professional nurses in executing both interpersonal and intervention skills as it relies on communication, so are the psychiatric roles.
As competent and proficient nurse, she is expected to use interpersonal and intervention skills in executing the management of the following: psychosis, depression and psycho–social disorders, to name some.

Figure 3.1 Modification of the communication process model.

**Phenomenological Approach:**

A phenomenological approach was used. Speziale and Carpenter (2007: 76) define phenomenology as a science whose purpose is to describe particular phenomena, or the appearance of things, as lived experience. Speziale and Carpenter (2007: 77) further explain phenomenology as a way of viewing ourselves, others and everything else with which we come in contact in life. Also, the authors state that the goal of phenomenology is to describe lived experience. Phenomenological design was used because it examines human experience through the descriptions provided by the people involved. The phenomenological approach was used to study participants. A phenomenological approach studies the phenomenon from the viewpoint of the research participants in the context in which action takes place.

Therefore, this design was relevant as the researcher focussed on describing the performance of newly qualified professional nurses observed by the participant. Brink (2006: 113) states that in attempting to describe the lived experience, the researcher focuses on what is happening in the life of an individual, what is important about the experience and what alterations can be made. In this way, the researcher can understand, for example, what ‘health’ or ‘caring’ means to the patient. Brink (2006:
113) further explains that there are certain basic actions that the researcher uses during the enquiry process, which are as follows:

- **Bracketing:**
  In this process, the researcher identified and set aside any preconceived beliefs and opinions that she might have about the phenomenon under investigation; in other words, the researcher identified what she expected to discover and then deliberately set aside any assumptions. The researcher set aside the fact that student training is intensive and students do not receive sufficient exposure to clinical areas (Brink, 2006: 113).

- **Intuiting:**
  This occurs when the researcher tries to develop an awareness of the lived experiences. The process requires the researcher to be totally immersed in the phenomenon under investigation, aided by the participants’ descriptions. The researcher reviews the data again and again until there is a common understanding. This stage occurs during the interviews (Brink, 2006: 113).

### 3.5.2 Research Method:

The qualitative approach was used. Brink (2006: 113) describes qualitative methods as focusing on qualitative aspects of meaning, experience and understanding. Multiple realities and subjectivity are valued in qualitative research, and are context dependant. The study focused on understanding the experiences, performance and care rendered by newly qualified professional nurses in mental health institutions. Speziale and Carpenter (2007: 21) further explained the characteristics found in qualitative research, as the belief in multiple realities, meaning that qualitative researchers believe that there are multiple realities out there that need to be researched, a commitment to identifying an approach to understanding which supports the phenomenon being studied, a commitment to the participant’s viewpoint, conducting the enquiry in a way that limits disruption of the natural context of the phenomena of interest, acknowledged participation of the researcher in the research process as well as the reporting of the data in a literary style rich with participant commentaries.
The study focused on understanding the experiences, performance and care rendered in institutions by newly qualified professional nurses. Speziale and Carpenter (2007: 21) also alleged that instead of searching for one reality and one truth, researchers committed to qualitative research believe that individuals actively participate in social actions. Through the interactions that occur, based on previous experiences, individuals come to know and understand the phenomena in different ways. Qualitative research provides opportunities for variations when using data collection.

3.5.3 Research Setting:

The research was conducted at the Chris Hani district, and the focus was on Lukhanji clinics and Komani hospital in the central part of the Eastern Cape. The participants were African and Xhosa speaking.

The researcher concentrated on those primary health services that were served by newly qualified professional nurses and the only mental health institution which was Komani hospital. Komani hospital is the only designated mental institution in the Chris Hani district. The researcher directed her focus on the primary health services around Whittlesea, which make up four clinics and only two clinics were utilised.

3.5.4 Population for the study:

Brink (2006: 123) cites that a population is the entire group of persons or objects of interest to the researcher, in other words, it is the group that meet the criteria which the researcher is interested in studying.

The target population would be the newly qualified professional nurses and including their supervisors, who supervise the newly qualified professional nurses.

In this study newly qualified professional nurses are part of the working force, rendering care in the stated institutions. Supervisors oversee the newly qualified professional nurses, and they were able to provide information about the care rendered in institutions. There are two population groups in the study that is the newly qualified psychiatric nurses and their supervisors.
3.5.5 Sampling method:

The sampling method was purposive, meaning that the targeted group has the characteristics that were required by the researcher. Wehmeier et al (2005: 1180) defines purposive as having a clear and definite purpose. The newly qualified psychiatric professional nurses and their supervisors would be giving us the required information. It was purposive in the sense that the variable that was to be studied was the newly qualified professional nurse together with their supervisors, and as such, newly qualified professional nurses and their supervisors were the characteristic of choice. The researcher was looking for meaning rather than frequency (Munhall, 2007: 530).

In this study purposive sampling was the targeted newly qualified psychiatric professional nurses who qualified between 2005 and 2009 together with their supervisors.

3.5.6 Sample size:

Sample size was the number of the participants involved in the research, taken from the total population included in the study. The sample was purposive that is all the newly qualified professional nurses who qualified between 2005 and 2009 and their supervisors were interviewed in the two community health centres and in Komani hospital until there was saturation with the data.

3.5.7 Inclusion criteria:

All the newly qualified psychiatric professional nurses, who qualified between 2005 and 2009 and who work at the mental institution and the two selected clinics as well as supervisors in the settings given above.

3.5.8 Exclusion criteria:

Professional nurses with more than five years practical experience, and their supervisors who were not part of the study.

3.5.9 Gaining access to participants:
The researcher obtained entry permission from the authorities to access the group to be studied. Brink (2006: 124) explains that the researcher has to limit the accessible population by adding a characteristic to the defined population, such as restricting the setting of the study to a particular area. The researcher received permission from the authorities of Chris Hani District and the Local Service Area. The clinics were visited by the researcher, and the study was explained to the supervisor, who in turn informed the participants.

3.5.10 Data Collection

3.5.10.1 Researcher as an instrument:

The researcher was used as an instrument in this research because she was the key person in data collection. In qualitative research observation and communication are used as an instrument (Botma et al, 2010: 83). The researcher conducted the interviews and filled in the answers in the space provided in the interview guide. The researcher was immersed in the data collected.

3.5.10.2 Unstructured interview:

Two interview guides were designed, one interview guide for newly qualified professional nurses and the other one was for the supervisors of the institutions where the newly qualified professional nurses work (Appendice: A). Open ended questions were used. The interview guide of the newly qualified professional nurses focussed on the ability and proficiency of these nurses in utilising psychiatric nursing skills and the interview guide of the supervisors focussed on the report of the performance of newly qualified professional nurses. Questions were designed and the appropriate probing was conducted. Responses were taken and written verbatim on the space provided in the interview guide.

Interviews were conducted in a single private room where confidentiality was maintained. Communication skills were used, the researcher listened attentively and kept on nodding to confirm attentive listening. Eye contact was maintained and probing
was done where necessary. The use of eye contact was important because that is where the researcher could pick up the non-verbal cues.

In each clinic two newly qualified psychiatric professional nurses were interviewed. The researcher stopped at two because it was noticed that data were saturated. Due to willingness of the group and the fact that they might come up with something new, focus group interviews were conducted. Interviews were conducted in two health clinics at Lukhanji LSA and Komani Hospital, (see Appendix B).

3.6 Data analysis: Making sense of data

Data in themselves do not answer questions, support or answer hypothesis (Burns & Grove, 2001: 642). The researcher has to make sense of data before presenting them. Data were analysed to describe abilities and proficiency of the newly qualified psychiatric professional nurses in utilising psychiatric nursing skills as well as the observations by the supervisors. Information from interview guides, interviews or observations are referred to as raw data.

Data were analysed using content analysis. The researcher first read through the content and developed possible codes. Common phrases from the content of the interviews were put on coding (level1). The researcher created another set of similarity to the content that is coding level 2. The researcher attached meaning to the two levels. Botma et al (2010: 224) allege that coding is the process of organising the material into segments of text before bringing meaning to the information. These were refined into categories that is families and members. Thus, themes were developed. It is critical to identify how statements or central themes emerge and how they are connected to one another if the final description is to be comprehensive and exhaustive (Speziale & Carpenter, 2007: 97). Visual displays were made namely repackaging, aggregating the data, and searching for relationships in the data, thus finding out where the emphasis and gaps in the data were.

3.7 Authenticity and trustworthiness of the study:
The study must answer to criteria against which trustworthiness of research can be evaluated. These criteria serve as classic contribution to qualitative research method. Trustworthiness is discussed by Marshall and Rossman (1995: 143-145) in De Vos, Strydom, Fouche and Delport (2005: 345) as shown below.

3.7.1 Credibility:

Authenticity refers to the extent to which the researcher fairly and faithfully shows a range of different realities. Brink (2006: 118) argues that in qualitative research, credibility and authenticity refer to internal validity. The above mentioned, including Botma et al (2010: 234) describe credibility as the alternative to validity. The goal of credibility is to ensure that the enquiry is conducted such that the participants are accurately identified and described. The aims and objectives of the study, description of the process and the pattern of interaction embrace the validity of the study (De Vos et al, 2005: 346). According to Speziale and Carpenter (2007: 342), credibility refers to activities that increase the probability that credible findings will be obtained. These experts argue further that the goal in qualitative research is to study the experiences of participants accurately. Babbie and Mouton (2009: 277) allege that the researcher should engage in prolonged, persistent observation, triangulation, adequacy, peer debriefing and checks from peers. The researcher was persistent in data collection (probing), read the data repeatedly, provided adequate time for interviews and asked the opinion of experts regarding the interview guide.

3.7.2 Dependability:

Dependability is the extent to which similar findings would be obtained through repeated research (Babbie and Mouton, 2009: 278). It is the alternative to reliability in which the researcher attempts to account for changing conditions in the phenomena being studied. The researcher understands that phenomena changes with social change (De Vos et al, 2005: 346). This implies that the researcher should be flexible. In this study dependability was upheld by considering ethical standards, namely quality, respect of participants and functioning within the research protocol.
3.7.3 Confirmability:

It is the traditional concept of objectivity. The study should be comparable to others and be confirmed by others so as to remove the study from the subjectivity (de Vos et al, 2005: 347). It is the extent to which the findings are the outcomes and not the biases of the researcher (Babbie and Mouton, 2009: 277). To enhance confirmability of this study, the researcher wrote constant notes throughout the study as described in data collection.

Confirmability is used to guarantee the findings, conclusions and recommendations supported by the data. There must also be internal agreement between the investigator’s interpretation and the actual evidence (Brink, 2006: 118).

3.7.4 Transferability:

Transferability refers to the probability that the study findings have meaning to others in similar situations (Speziale and Carpenter, 2007: 49). As references showed this study is aligned with other studies. It is the alternative to external validity or generalizability. This means demonstrating the applicability of the findings by the investigator. The fact that data were collected from newly qualified professional nurses and their supervisors strengthened the usefulness of the study to other settings (De Vos et al, 2005: 346.)

The above explanation has served to give the trustworthiness of this study.

3.8. Ethical considerations:

It is a state in which the researcher must adhere to the research principles for conducting research in which human beings are involved (Botma et al, 2010: 56).

3.8.1 Confidentiality:

Confidentiality means protection of participant’s information by ensuring anonymity and privacy (Brink, 2009: 47)
The prospective participants were assured of confidentiality. The information given by the participant would not be divulged. No names were used, but numbers were used. The information will be kept in locked cabinets.

Privacy was also ensured by conducting activities in conducive and private environments.

3.8.2 Obtaining Permission:

The moral question often comes to the fore when a study involving human beings is conducted, hence the consideration of human dignity. The principal objective is to render services to humanity with full respect for the dignity of man (Speziale and Carpenter, 2007: 57). To comply with ethics, the researcher secured permission from the ethics research committee, of the University of Fort Hare to conduct this study and permission was granted. Check Appendice C.

The researcher also wrote letters to Provincial and District authorities seeking permission to conduct this study at Chris Hani District, Lukhanji LSA and Komani hospital. Permission was granted. Check Appendices.

3.8.3 Informed consent:

According to Trumble et al (2007: 496) informed consent means giving permission having sound understanding of the facts. Full information was given to the prospective participants regarding the nature of the study. The participants were informed of their rights and that they could withdraw at any stage of the research if they did not feel comfortable, without fear of intimidation (Check Appendices). Participants were informed that they would retain their autonomy.

Informed and written consent was obtained from the participants. The research was conducted on a voluntary basis.
3.9. Conclusion:

After implementation of the method, namely data collection, focus was put on data analysis. Therefore, like vegetables and meat, data are cleaned and processed before they can be appreciated.

The interview guide and the interviews are shown in the appendices.
CHAPTER FOUR: DATA ANALYSIS AND INTERPRETATION:

4.1 Introduction

The computer programme Atlas. ti was used for processing and managing qualitative material. Botma et al (2010: 227) state that, the programme is an efficient means of storing and locating qualitative material and facilitates comparing different codes. During the analysis, the researcher repeatedly read the verbatim transcripts in order to acquire an understanding of the interviews and also to become acquainted with the data that were collected during the interviews.

4.2 Transcription of data:

The collected data were transcribed before interpretation. Although transcribing interviews took time, the benefit was familiarity with the data (Munhall, 2007: 252). Botma et al (2010: 214) argue that verbatim transcription is a critical step in preparing for data analysis, and the researcher needs to ensure that transcriptions are accurate, that they validly reflect the totality of the interview, and that they facilitate analysis.

4.3 Familiarisation and immersion:

This process started while gathering the data. The researcher began to develop ideas and theories about the phenomenon under the study. This compelled the researcher during the process of data gathering, to start with some data analysis so that she could form some kind of preliminary understanding of the data’s meaning (Botma et al, 2010: 226). The researcher immersed herself in the data, by reading the notes many times so as to gain a better understanding of them.

4.4 Grouping of the data:

Similar phrases were grouped together under the different topics. See Appendix: F.

4.5 Coding of the data:
Botma et al (2010: 224) allege that coding already starts while the researcher is identifying themes. The data were coded and linked to one of the identified themes. The following stages were used when coding the data:

### 4.5.1 Stages of coding:

<table>
<thead>
<tr>
<th>Stages of Analysis</th>
<th>Analysis process</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Creating a Hermeneutic Unit (an idea container)</td>
<td>A new Hermeneutic Unit was opened to enclose data, codes memos and other structures under a single name.</td>
</tr>
<tr>
<td>2. Association of data files (Primary Documents) with the Hermeneutic unit</td>
<td>Selected a file of the interviews and loaded them in the Hermeneutic unit.</td>
</tr>
<tr>
<td>3. Coding of the data</td>
<td>Read and selected text passages (or identified areas in a document) that were of further interest and assign code words.</td>
</tr>
<tr>
<td>4. Creation of Families or categories</td>
<td>Data segments were compared differently or similarly, that is putting similar codes in one family.</td>
</tr>
<tr>
<td>5. Formulation of networks</td>
<td>Linked similar codes together and formulated a network.</td>
</tr>
<tr>
<td>6 Interpretation and checking</td>
<td>Results integrated into a thorough description of phenomena.</td>
</tr>
</tbody>
</table>

The researcher analysed the responses of each participant in relation to each question asked. Level 1 open coding done, that is highlighting a string of words of interest then assigning a descriptive code, which is level 2. Categories / families were then created which in turn led to the creation of themes and sub – themes or clans.

### 4.4 Development of themes:
It was very important for the researcher to spend some time with the participants so as to understand their language before using the research language. While reading through the text, the researcher identified main and subthemes (Botma et al, 2010: 226). Development of themes see Appendix G.

4.6 Interpretation:

Positive and negative themes emerged. Visual displays of positive and negative themes will be done. The researcher also organised the grouping of categories as follows:
4.6.9. VISUAL DISPLAY OF THEMES:

**Figure 4.1 Positive Themes**

- Problem solving
- Continuous mentorship / support
- Acceptance
- Feedback
- Users, colleagues and community
- Assertiveness & cooperation
- Individualisation
- Good interpersonal relations
- Competence/perform well

Newly qualified professional nurses
Figure 4.2 Negative themes

- Shortage of material resources
- Human resource shortage
- No support of clients
- Poor communication

Newly qualified professional nurses

Problem solving

Community Health Worker (CHW)

- Home visits/outreach programme
- Tracing defaulters
- Treatment monitoring
- Health education
4.7 Discussion of the findings:

4.7.1 Positive themes:

4.7.1.1. Good interpersonal relations

Newly qualified nurses accept their clients as they are and are not judgemental. They give them support particularly those who are not supported by their families. Activities / projects are started for the clients both in the community and in hospital. In the community, there are garden projects and support groups where they support each other and work as a team. Botma et al (2010: 247) state that solidarity and cohesiveness prevail amongst community members who work as a team. Likewise, there are activities conducted by patients in the hospital and for this, patients are grouped according to age and their diagnoses.

Newly qualified nurses interact well amongst themselves and with their supervisors. Activities are embraced by multidisciplinary collaboration, where they communicate with social workers about their clients and this collaboration strengthens and builds trust amongst the team members.

4.7.1.2. Competence of newly qualified professional nurses

Supervisors commend the newly qualified professional nurses, stating that they carry out their delegated tasks well. This is illustrated by their verbatim quote:

‘They are performing well and they are very much co–operative, what I like is that if they do not understand they ask, and they are always attended to’.

They also show their co-cooperation and assertiveness. They do health education to clients and their families, when they accompany them for review and repeats of medication. They also do referrals, for example when medication is out of stock, they refer the client to hospital. If the clients are unemployed, the newly qualified professional nurses refer them to social development for food parcels and for disability grants.
4.7.1.3. Mentoring of newly qualified

The old professional nurses in the field provide mentoring to the newly qualified professional nurses. Supervisors indicated that each of these nurses is unique. Some can function independently and are proactive, while some are mentored during the period of orientation and induction. This was illustrated when they: ‘People are unique, their performance differs. Through mentoring, some perform well, and others still need mentorship. We also identify their shortcoming and support them’. The knowledge gap that exists is not significant.

4.7.1.4. Individualisation of clients and staff

The newly qualified professional nurses give individual attention to their clients. They share health education with clients and their families if they have accompanied them, emphasising compliance to medication for the treatment to be effective. They share knowledge with them and encourage families to support their users.

Munhall (2007: 144) states that the degree of complexity of the work is then established according to the abilities required and the amount of work should also be estimated. She further states that the nursing practitioner’s professional – ethical and legal framework is also analysed to determine whether this task / responsibility falls within the legal scope of practice. Supervisors commend them by stating that they carry out the delegated tasks well. This is also illustrated by quoting the supervisor verbatim: ‘With the nurses that we have, we are not complaining. They carry out their delegated task well’. The newly qualified professional nurses perform according to the statement of the legal framework mentioned previously.

4.7.1.5 Acceptance of clients and personnel

Newly qualified professional nurses accept their patients unconditionally, this is demonstrated when they say ‘experiences are wide because we need not judge them, instead involve them in many activities and come closer to them, motivate them on compliance and be free and show welcoming attitude to them and be supportive’. The
newly qualified professional nurses support their clients. Some clients do not come with their relatives. Those who need assistance are referred to relevant services like social development.

Newly qualified professional nurses are accepted by their supervisors, who involve them in the activities performed by staff members, showing acceptance into the main stream of professionals.

4.7.1.6. Feedback on activities

Newly qualified professional nurses provide feedback on activities that have taken place. One of the supervisors said that they do orientation and mentoring with these professional nurses who then give feedback to the supervisors. Supervisors commend them by stating that they are pro-active and co-operative.

4.7.2 Negative Themes

4.7.2.1 Shortage of resources

➢ Material Resources
The newly qualified professional nurses experience drastic shortage of material resources especially medication. They state that this shortage of medication makes them feel ineffective in their work. e.g. when there are no medicines, they have to refer clients to Komani Hospital to fetch treatment, some do go but others do not, expressing the lack of funds for transport. This leads to noncompliance of medication, which leads to relapse of patients and a high re-admission rate. Clients have mentioned that they stay for about six months not and still do not receive the modecate injection at clinics. A modecate injection is mainly given to clients who do not comply with oral medication. One can imagine the results, when it is out of stock for such a long period and clients are given oral treatment again.

➢ Human Resources
There is a drastic shortage of nursing staff. Some of the activities cannot be done because there are long queues of clients and few personnel. This impacts negatively on patient care in terms of health education and implementation of outreach programmes.

Health education on conditions of mental illness is not done because there is no time to do it. Families of users are not informed of situations, hence some of the patients are neglected because they lack knowledge. They usually do not know what to expect from the users.

Community outreach programmes are also not initiated because newly qualified professional nurses want to attend to clients and assist them as quickly as possible. One wonders if quality care is even rendered to clients because of staff shortage.

4.7.2.2 Poor communication

Newly qualified professional nurses also complain of poor communication. They mentioned that they refer clients to Komani hospital via Frontier hospital where 72 hour observation is done, but they never receive a report back about the patient. The patient will be admitted and be given treatment and thereafter is discharged back to the community without communicating with the primary health services nearest to them. The staff only sees the patient when he / she come back for a repeat treatment or if they have relapsed.

The poor communication also impacts on the services negatively because, the client will be brought sometimes to the health care services by community members and police, because they have become a danger to themselves and community members. This aggravates the stigma attached to mental illness.

4.7.2.3 Lack of support to users

It has been clarified from the interviews that some patients come on their own to fetch medication and are not accompanied by family members. This makes it impossible to teach the psychotic patient about their condition and to elicit compliance to treatment.
Some patients come to the clinic to report their family members, who take their disability grant money and use it for themselves and so neglect the user. Nurses have a duty to support such patients emotionally and to refer them to social development.

4.7.2.4 CHW doing preventive work or health promotion

CHW mainly do the preventive work whilst newly qualified professional nurses stay at the services doing mainly curative work i.e. attending to minor ailments and issuing repeat medication.

CHW go out to communities to do health promotions because they do health education in communities, tracing defaulters and monitoring treatment. They come to report to the newly qualified professional nurses when there are complications in the community but the professional nurses seldom go there when they have to support what has been reported by CHW.

Community outreach programmes that are conducted focus mainly on HIV / AIDS and tuberculosis (TB). There are also multidisciplinary teams who only focus on these conditions. Multidisciplinary teams are not there for mental health care users, this is illustrated by the following quote: ‘no, not at community level we do not have the multidisciplinary team, we refer our clients to Komani hospital via Frontier hospital where the 72 hour assessment is done’.

4.8 Conclusion

The data were analysed using the coding system. Atlas. ti enabled the researcher to organise the text, along with coding and identification of themes. The researcher spent time with the participants to acquaint herself with their language, until she could form some kind of preliminary understanding of the data’s meaning. The richness and depth of the data, interpreting and synthesizing the information, and gaining a true understanding of a phenomenon, together made qualitative inquiry a fulfilling and unforgettable experience (Botma et al, 2010: 235).
CHAPTER 5

5. Conclusions, Findings, Limitations and Recommendations

5.1 Introduction

In this chapter, the researcher presents conclusions on the findings of the study, limitations and recommendations. The process of this research involved emerging questions and data collected in the participant’s settings. Data analysis inductively built up from specific information to general themes and the researcher made interpretations of the meaning of the data, hence now, the conclusions of the study are formulated (Botma et al, 2010: 235).

5.2 Conclusions and findings:

The objective that was set for this study was the following:

Explore and describe the ability to produce psychiatric nursing skills by the newly qualified professional nurses at the Chris Hani District Psychiatric Health Care Services in execution of tasks as stipulated by the competencies.

5.2.1 Execution of tasks by newly qualified Professional Nurses:

The study revealed that, according to the perception of the supervisors of the newly qualified professional nurses, newly qualified professional nurses are unique, in relation to other professional nurses. Performance depends on the individual’s ability, because some perform independently while others need some mentoring. The supervisors did not complain because the newly qualified professional nurses executed delegated tasks well, quoting them verbatim ‘They are performing well and they are very much co-operative, what I like is that if they do not understand they ask, and they are always attended to’. There is support for the newly qualified professional nurses because when they are involved in community services, the supervisors always pair them with more experienced professional nurses in the unit or clinic.

The results of this study showed that the newly qualified professional nurse performed as stipulated by competences, but there were many challenges that hindered their
performance as identified by the researcher. These were: a shortage of human and material resources, the observation that mental illness is not a priority to the department of health, as well as the lack of skills development for the newly qualified professional nurses.

5.2.1.1 **Shortage of human and material resources**

Shortage of resources impacted negatively on the performance of newly qualified professional nurses. Programmes were initiated in the institutions but with no sustainability because of staff shortages. Sometimes clients undertake activities on their own without supervision from the professional nurses.

According to the competencies, the newly qualified professional nurses are expected to provide health education to users, families and communities on conditions of mental illness and prevention of mental illness. The researcher found that newly qualified professional nurses only conducted health education dealing with compliance to medication, to clients and some family members who accompanied the users. The reason was that they were short staffed and there was a long queue of patients who needed to be attended to. As such, they could not educate users and families about the condition itself, predisposing factors, side effects and its management.

The newly qualified professional nurses focussed mainly on the curative aspects of care, rather the prevention of disease and promotion of health. Lack of outreach programmes by professional nurses and poor communication contributed to relapse of patients. Outreach services were mainly conducted by CHW. If professional nurses attend to outreach programmes, they focussed mainly on HIV and AIDS.

CHW conduct home visits, trace defaulters and monitor treatment intake. They also provide health education, but their health education is limited to their scope of practice. They are not able to teach about the conditions of mental illness, side effects and their management. This situation contributes to rehospitalisation and roaming around of patients with unkempt appearances, which eventually compromises the efficiency and promptness of the newly qualified professional nurses.
Professional nurses have a holistic approach to clients as they practise integration of services. Regarding integration of services, mental health care users exhibit impatience at times. They do not want to wait in the queue when they come for repeat medication, compelling nurses to talk to community members on their behalf to ensure quick attendance. Integration had its own challenges but it alleviates the stigma attached to mental illness.

It has been revealed in this study that, there was a shortage of medication at primary health care services for an example modecate which was out of stock for a period of time. Clients are given the modecate injection because they default on oral medication. When modecate is out of stock for about six months, clients definitely relapse because they are given oral medication or are referred back to Komani hospital for treatment. Most clients do not go to Komani hospital for repeat medication, due to money issues and this contributes to more users relapsing.

There is a communication problem about previously referred patients who are not referred back to clinics during discharge from a mental institution. The client would only be seen when she or he came for repeat medication or when the client had relapsed or been identified by the CHW that he was back to the community. This compromises the efficiency of newly qualified professional nurses, because more patients are then re-admitted to mental institutions. Quoting the newly qualified professional nurses verbatim ‘Once they are on treatment they stabilise and behave well. We almost nurse the same patients because they become controlled on treatment and they are discharged. They relapse out there and come back’.

5.2.1.2 Mental illness not a priority

Mental illness is not a priority to the department of health, because it was detected that the outreach programmes that were conducted, were only focusing on HIV and AIDS, and not on mental illness. The newly qualified professional nurses are faced with other issues that are a challenge to mental illness. These are the status quo of mental health service delivery, disease profile, neonatal mortality, family violence and child abuse in all forms as well as human trafficking. From the above, mental health care service
delivery is poor, as professional nurses focus on curative care only. At the clinic, mental health care users wait in the long queues, and are attended to only after the majority of clients have been seen. The logic is that mental health care users are few compared to general users.

The newly qualified professional nurse complains of staff shortages which jeopardise their ability to prevent disease and promote health. Outreach programmes are intended to increase awareness of mental illness. Mental illness could be prevented if community members were aware of predisposing factors like substance abuse and lifestyles. Family members are faced with the social stressor of living with users but lack adequate knowledge about the conditions of mental illness. Staying with the user predisposes the family to more stressors, which may also cause mental illness in other family members. Deinstitutionalisation is promoted so that members may be cared for, in their communities. Family members need to be informed about conditions of mental illness, predisposing factors, side effects and management thereof, so that they can manage mental illness and prevent new occurrences. Lewis and Uys (2004: 4) argue that the community psychiatric nurse must work in a holistic approach, prioritising the prevention of disease and the promotion of health wherever possible, but also ensuring adequate treatment and rehabilitation.

Disease profile has changed. The researcher identified that some clients acquired mental illness because they could not accept their positive HIV status. Mental illness must be an integral part of outreach programmes. In this study, the researcher indicated that the nature of disease, particularly mental illness prohibits any benefit from education. For that reason, it would be better for professional nurses to conduct awareness creation campaigns so as to prevent the occurrence of mental illness and minimise stigma attached to mental illness (Uys and Middleton, 2004: 75).

Psychosocial disorders cause depression in mothers. Reduction of psychosocial disorders is one of the goals, which needs to be achieved for a better life for all. Women have a vital role to play in the achievement of family health and the community in general (Rasaaq, Omolola and Oladoyin, 2004: 51). Therefore their mental health is imperative for their effective and productive participation. For achievement of health in
South Africa, mental illness needs to be examined. There is a myth that needs serious attention, the fact that people with mental illness are asexual. Some of them are HIV positive and therefore spread the disease, without cognisance of the myth. With the myths mentioned above, there would be no health achievement in South Africa.

This study revealed that, family violence, human trafficking and child abuse were aspects that were not dealt with by the newly qualified professional nurses due to staff shortages. Lewis and Uys (2004: 4) alleged that reduction of the incidence of family violence and child abuse needs a holistic public health approach. For this to be achieved, it needs a multidisciplinary approach. Multidisciplinary teams were only found in institutions and not in primary health services, those teams in primary health services focus only on HIV and AIDS, and tuberculosis. The researcher noted that mental illness is not a priority in the department of health. Uys and Middleton (2004: 75) identified that South African medical aids and state – funded health systems discriminate against mental illness. Outreach programmes emphasizing awareness campaigns, are of prime importance to promote sound mental health in the communities and minimise the stigma attached to mental illness (Uys and Middleton, 2004: 75). Staffing norms must be adhered to, so that the newly qualified professional nurses would be able to attend to all aspects of mental illness and give mental illness the priority it deserves leading to a more effective performance.

5.2.1.3 Lack of skills development

In primary health services, integration of services is promoted on well as a holistic approach. Some of the newly qualified professional nurses complained that, they had to refer clients when voluntary counselling and testing is to be conducted because they lack the expertise to execute the task. This study showed that the performance of the newly qualified professional nurses was hindered. They communicated this matter to their supervisors, who in turn reported to them that they had submitted their names to the skills development officer.

5.2.2 Findings:
According to the perception of the supervisors of newly qualified professional nurses, they performed well because they could carry out the delegated tasks well. Performance of newly qualified professional nurses was hindered by some health care aspects however, such as, shortage of resources, mental illness not considered a priority and the lack of skills development.

The study revealed that important aspects of mental illness were not attended to. Families and community members lack knowledge about mental illness although the newly qualified professional nurses were prepared according to the competencies mentioned in the study, this is illustrated by SANC (1990) in literature review that registered nurses do not apply frequently their theoretical knowledge of nursing in practise. It was discussed in the study that, the Mental Health Care Act (Act 17 of 2002) states that patients be nursed in their communities, this could be achieved if staffing norms were adhered to, and the patients feeding in dirty bins, roaming around the streets of Queenstown and surrounding areas would be minimised. Newly qualified professional nurses could then focus on prevention of disease and promotion of health. It has been found that some of the themes from the newly qualified professional nurses complemented each other, themes like shortage of staff, shortage of material resources, long queues due to integration, poor communication and CHW doing the preventive care whilst the newly qualified professional nurses were focussed on curative care. Themes from the supervisors also complemented each other, supervisors were satisfied with the performance of the newly qualified professional nurses. Themes like, competence, feedback, assertiveness, co – operation, support and good interpersonal relations are interrelated. This identifies the authenticity of responses by both groups. Question 3 in the interview guide for newly qualified psychiatric professional nurses, the researcher did not conduct re – interviews, because follow up of questions contained a problem solving on the challenges which talks to intervention skills.

5.3 Limitations:

The study was conducted in one District and one sub district of Lukhanji. If the study was conducted in another region, generalisation would be feasible.
5.4 Recommendations:

The following recommendations are considered appropriate to the findings of the study:

5.4.1 Establishment of awareness campaigns

Awareness campaigns need to be conducted to prevent new occurrences of mental illness and to promote mental health. Outreach programmes need to continue but must focus on all aspects of health care, not to single out one aspect of care like HIV and AIDS. Multidisciplinary teams need to be available in institutions and in primary health care service and they must also focus on all aspects of health including mental health. CHW need to be empowered on predisposing factors of mental illness so that they continue with the good work that they do. Families and communities also need to be empowered and involved in the care of the users, this would serve to reduce the stigma attached to mental illness and lead to better management of mental illness and support of the users (Uys and Middleton, 2004: 75). Practice can be developed if the clinic staff are trained in professional values, planning the programmes and in quality care.

5.4.2 Improvement of staff and material resources

The performance of newly qualified professional nurses was impacted negatively by staff shortages and shortage of medications. Staffing norms need to be adhered to, because they also impact negatively on nurse training, as the professional nurses do not perform their educational role to students any more. Patients do not receive quality care when two adjacent wards can be manned by one professional nurse. The staff should be increased so as to enhance the opportunity for home visits. Professional nurses are in a position to create more learning opportunities for developing nurses.

5.4.3 Criteria for referral system

There must be established criteria for referral system. Professional nurses at primary level must not just see a patient coming for repeat medication, not knowing when the patient was discharged from the hospital. This would assist in reducing the relapse rate of patients, because even if a patient is not coming for repeat medication, their discharged could be traced before relapse.
5.4.4 **Strengthening of skills development**

A holistic approach is encouraged so as to treat patients in totality. Integration of services is also promoted because it assists in combating the stigma attached to various illnesses. All nurses should be given all the necessary skills to execute a holistic approach. Nurses should not have to move around when treating a patient, or have to refer the patient because they themselves lack some skills. Problem based learning may be the solution to broad learning by nurses.

5.5 **Summary**

The researcher described the conclusions, findings, limitations and recommendations based on the findings as indicated in the purpose of this study.

5.6 **Conclusion**

In this study, the performance of newly qualified professional nurses was researched, and discussed at length. Factors that hindered the performance of newly qualified professional nurses were also discussed and recommendations were suggested.
6. Reference list:


Parahoo, K. 2006. *Nursing Research.* United Kingdom. Macmillan


APPENDIX: A

INTERVIEW GUIDE 1: FOR NEWLY QUALIFIED PROFESSIONAL NURSES.

1. How would you describe your interpersonal experiences in caring for a mental health care user?
2. Please describe your intervention to challenges that you have identified during your work as a professional nurse.
3. What skills do you think are necessary for integration of services?
4. Describe if there has been a need to counsel users?

INTERVIEW GUIDE 2: FOR SUPERVISORS

1. How would you describe your supervisory experience of newly qualified professional nurses in terms of their performance on specific procedures?
2. Please describe your relations with newly qualified professional nurses?
APPENDIX: B

INTERVIEW No: 1 (PN)

Community Pyschiatric Nurses

Date: 13th 04. 2011
Starting time : 08h30
Finishing time : 08h50
Total time : 20 minutes

PART A

Demographic Data:

Age
24 – 29 years  x
30 – 60 years

Marital Status
Single  x
Married
Other specify

Gender
Male  x
Female

Period of employment
PART B: INTERVIEW

Researcher : 1. How would you describe your interpersonal experiences in caring for a mental health care user.

Participant : There is not much experience with these patients because they come for repeat of medication and we only do health education on compliance of medication and to the relatives if the user is accompanied by them. Also the nurse must be observant so that she can be able to assess and diagnose.

Researcher : You only do health education on compliance not about the condition, causes, effects, signs and symptoms to the family?

Participant : There is no time for that, because we are short staffed and patients are waiting outside the consulting room for their turn to come in.

Researcher : Tell us about outreach programmes like awareness campaigns on Mental health?

Participant : Its only community health workers who go out to the community, we go only when they have reported some problems. Sometimes we organise and do a function like awareness on substance abuse.

Researcher : Can you give an outline of the activities of the Community Health
Worker (CHW) from which the professional nurse is relieved?

Participant: They do home visits, monitor treatment intake, dosage and all.

Also check the environment where the patient stays if it is conducive.

Also check source of income, then they come and report to nurses.

They also monitor the behaviour of the patient.

Researcher: 2. Please describe your intervention to challenges that you have identified during your work as a professional nurse.

Participant: There is a shortage of resources material and human, i.e. nursing staff, medication and equipment. This shortage of medication does not make us to be efficient in treating our patients because we have to prescribe what is available and not what will relieve signs and symptoms. There is also lack of proper skills development.

Researcher: What do you mean by a lack of proper skills development?

Participant: Like having a client & when you do history taking, you find out that the patient need to be done voluntary counselling and testing (VCT), but we have to refer because we were not sent to courses for HIV/AIDS. This does not enable one to treat patient in totality.

Researcher: What do you normally do when faced with challenges (name them)?

Participant: 1. Patients defaulting treatment – we normally send the CHW to trace them and check the problems contributing to defaulting of medication.
2. Poverty – clients complaining of unemployment and complain that they cannot take medication on an empty stomach. Some of the patients are sent to the local doctor for disability grant, and some are sent to social development for food parcels.

3. Relatives not taking care of their immediate families – we send CHW to call them so that we give them health education about importance of caring for their relatives.

4. With skills development – we have communicated with our supervisors about the problem and they have taken our names to the skills development person at district office.

Researcher: 3. What skills do you think they are necessary for integration of services?

Participant: All patients come at the same time to the clinic, and they all want to be assisted at the same time.

Researcher: Please describe your efforts in overcoming the integration consequences?

Participants: It depends with a particular nurse because if you talk to clients, they can wait and some are manipulative but if you explain to them they do understand, also depending on the condition of the patient at that point in time especially those who are stable on treatment. They only want one to show respect to them unless if the
patient is aggressive already.

Researcher : 4. Describe if there has been a need to counsel users?

Participant : There is a need to counsel when giving treatment because you can’t just give treatment without counselling the patient. Also educate about side effects and how to manage them. Even if he / she is in institution you support him / her to have hope & continue with medication.
INTERVIEW No: 2 (PN)

Community Psychiatric Nurses

Date: 13\textsuperscript{th} 04. 2011

Starting time : 09h00

Finishing time : 09h25

Total time : 25 minutes

PART A

Demographic Data:

Age

24 – 29 years \textbf{x}

30 – 60 years

Marital Status

Single \textbf{x}

Married

Other specify

Gender

Male

Female \textbf{x}

Period of employment

1 to 2 years
PART B: INTERVIEW

Researcher : 1. How would you describe your interpersonal experiences in caring for mental health care users.

Participant : Is to make sure that the patient is adhering to his / her treatment, by coming every month for repeat of treatment, to control signs and symptoms.

Researcher : Are there any strategies that you have implemented to ensure that the patient adheres to treatment?

Participant : We do give health education on importance of compliance when they come for repeat of treatment, some are accompanied by relatives, some come on their own. We also ask Community Health Workers (CHW) to monitor treatment intake of patients.

Researcher : Is your health education based on compliance issues only not focusing on other aspects like the condition itself, causes etc?

Participant : It is time consuming to dwell much on health education, as we are short staffed and there are long queues of patients who want to be attended.

Researcher : Do you conduct home visits where one can dwell more on health education or educational campaigns on mental health?
Participant: No, these are done by community health workers (CHW).

Researcher: Can you give an outline of the activities of the CHW from which the professional nurse is relieved?

Participant: When the clients have defaulted they go and trace them but in cases where there is a need for a professional nurse we do go e.g. when a patient is belittling the CHW. I do the follow up to educate the patient and show them cause of mental illness like substance abuse.

Researcher: 2. Please describe your intervention challenges that you have identified during your work as a professional nurse?

Participant: Shortage of staff as a result we cannot do home visits or educational campaigns, we only go when the CHW have reported the problem. Shortage of drugs / medication also poses a problem in our practise. Also referrals – when we refer patients to the second level of care, namely Komani hospital, we do not get feedback about the patient. One will only see the patient coming for repeat of treatment or when the patient has relapsed again.

Researcher: What do you do when there is a shortage of drugs.

Participant: We refer our patients to Komani Hospital for repeat of treatment.

Researcher: Explain if you communicate these problems to your supervisor?

Participant: We did communicate these problems with our supervisors, and they
promised to communicate it further to their management meetings so as to improve communication, but they did not give us the report back.

Also when we are out of drugs we always refer our patients to the second level of care to fetch their medication.

Researcher : Describe your problem solving skills in combating challenges (name them).

Participant : 1. When medication is out of stock – we normally refer our patients to fetch their medication at Komani hospital, and we order more supply for the coming month. It only becomes a problem when the medication is not supplied by the Depo for several months just like modecate which has been out of stock for three months.

2. Lack of feedback – we communicated the matter to our supervisors, who also promised to take the matter further to improve communication.

3. Relapsing patients – CHW trace the defaulters for us but it becomes difficult if the patient was admitted then discharged without us knowing because, we only see that patient when he/she has relapsed and we have reported this problem to the supervisors.

Researcher : 3. What skills do you are necessary for integration of services?
Participant: Patients are no longer coming on different days for their treatments or minor ailments due to integration and want to be assisted at the same time with all others.

Researcher: Please describe your efforts in overcoming the integration consequences?

Participants: We normally request other clients in queue to allow us to start with mental health care users especially when they seem to be impatient and unstable.

Researcher: 4. Describe if there has been a need to counsel users?

Participant: There is always a need to counsel them so as to re-assure them and promote compliance.
INTERVIEW No: 3 (Supervisor)

Community Psychiatric Nurses

Date: 13th 04. 2011

Starting time : 09h30
Finishing time : 09h55
Total time : 25 minutes

PART A

Demographic Data:

Age

24 – 29 years
30 – 60 years x

Marital Status
Single
Married  x
Other specify

**Gender**
Male
Female  x

**Period of employment**
1 to 2 years
3 to 5 years
5 and more  x

**PART B: INTERVIEW**

Researcher   : 1. How would you describe your supervisory experience of newly qualified professional nurses in terms of their performance on specific procedures?

Participant    : They are performing well and they are very much cooperative, what I like is that if they do not understand they ask, and they are always attended to.

Researcher   : Do they show skills in carrying out various tasks?

Participant   : With the nurses that we have, we are not complaining. They carry out their delegated task well.

Researcher   : 2. Please describe your relations with the newly qualified professional
nurses?

Participant: We have good relations, they are very much co-operative and as I have said, they do carry out their tasks well.
INTERVIEW No: 4 (PN)

Community Psychiatric Nurses

Date: 13th 04. 2011

Starting time               :           10h00
Finishing time             :           10h25
Total time                    :           25 minutes

PART A

Demographic Data:

Age
24 – 29 years
30 – 60 years   x

Marital Status
Single        x
Married
Other specify

Gender
Male
Female        x

Period of employment
1 to 2 years
PART B: INTERVIEW

Researcher : 1. How would you describe your interpersonal experiences in caring for a mental health care user.

Participant : Experiences are wide because we need not to judge them, instead involve them in many activities and come closer to them, motivate them on compliance and be free and show welcoming attitude to them and be supportive.

Researcher : What do you mean by coming closer to them, and in which activities do you involve your patients?

Participant : For instance here at the clinic, they have a gardening project. Some alternate. They also have support group that encourage them to comply with treatment and we have started a soup kitchen for the users.

Researcher : 2. Please describe your intervention to challenges that you have identified during your work as a professional nurse?

Participant : Support groups are held on Thursdays every week but now we are no longer assisting them due to shortage of staff. Some are still coming for gardening project and are continuing without our help. Sometimes they are helped by students when they are allocated
at our clinic.

We have sessional doctor and no psychiatrist that come to see our clients.

Some patients come for repeat of medication, and when it is out of stock we are forced to send them back to Komani hospital for repeat of medication.

Researcher: Do you have a multidisciplinary team with whom you can discuss your patients and their management?

Participant: No at community level we do not have the multidisciplinary team, We refer our clients to Komani hospital via Frontier hospital where 72 hour assessment is done.

Researcher: Do you conduct home visits, if not who conducts them?

Participant: No, it's CHW who do home visits, they report to us and if there is a problem they cannot solve they report to us.

Researcher: Can you give an outline of the activities of the CHW from which the professional nurse is relieved?

Participant: They assist us by tracing defaulters so that we can be able to treat the patient before she/he relapses.

They also assist with monitoring of patients if they are taking treatment well and come to report about the patients. They also help with health education of patients.
Researcher : Describe your problem solving skills in combating challenges (name them).

Participant : 1. Client discharged from Komani hospital with wrong medication and Discharge summary that does not belong to him – we had to phone The hospital and that was corrected.

2. Condition of our patients – it becomes a problem when one Identifies that HIV counselling and testing (HCT) needs to be done Because of their state of mind or condition so family members need to be involved.

3. Sometimes family members complain that there is lack of care at Komani hospital because their family member absconded and nobody did the follow up and they came to complain at the clinic – so we phoned Komani and staff complained of transport problem that they could not go out to trace the patient but they reported the absconded patient to the police.

Researcher : 3. What skills do you think are necessary for integration of services?

Participant : The problem arises when other staff members are off because we Become short staffed and patients become impatient.

Researcher : Please describe your efforts in overcoming integration consequences?

Participants : We attend to our clients on daily basis and all the professional
Nurses on duty do attend to the patients.

Researcher : 4. Describe if there has been a need to counsel users?

Participant : There is a need because some of them are sick due to toxic psychosis and some due to HIV positive status and some do not have insight to their illness.

Researcher : How do you manage the situation of a psychotic user, and one with no insight?

Participant : We monitor treatment intake and continuously re-orientate the patient to reality and we also talk to their relatives and reassure them.
Date: 13th 04. 2011
Starting time : 10h30
Finishing time : 10h55
Total time : 25 minutes

PART A

Demographic Data:

Age
24 – 29 years x
30 – 60 years

Marital Status
Single x
Married
Other specify

Gender
Male
Female x

Period of employment
1 to 2 years x
PART B: INTERVIEW

Researcher : 1. How would you describe your interpersonal experiences in caring for a mental health care user.

Participant : Users are very manipulative, one has to be vigilant so as to identify that & control the situation. It is also difficult to interact with them frequently as they come only for repeat of medication.

Researcher : Please explain what do you mean by being manipulative?

Participant : Like when patient is defaulting treatment he/she will tell you that he / she has no food to eat and cannot take treatment on empty stomach, whereas the patient is getting disability grant so one has to be vigilant, identify that and manage the situation.

Researcher : Do you conduct home visits where one can see and identify those problems?

Participant : CHW are doing the home visits, they report problems and we go to check and try and solve the problems or refer to relevant stakeholders

Researcher : Can you give an outline of the activities of the CHW from which the professional nurse is relieved?

Participant : They help us to trace the defaulters especially when we have students
they go with them.

They monitor treatment intake for patients. They do health education to our communities. They also ask us to make referrals to social services.

Researcher: 2. Please describe your intervention to challenges that you have identified during your work as a professional nurse?

Participant: Client’s attitudes – some clients have bad attitude, they come to the clinic for the first time and is impatient and wants to be attended first in front of the patients who have been at the clinic before him/her. We also have shortage of staff as a result we cannot continue with programmes that we have started.

Researcher: Which programmes are those?

Participant: Like gardening project, but our clients do continue with it on their own, we also started support groups and now we are not able to assist clients, and our soup kitchen is on hold now.

Researcher: Describe your problem solving skills in combating challenges (name them).

Participant: 1. Shortage of resources e.g. drugs – then we refer patients, sometimes they do not go & default treatment then thereafter they relapse.

2. We do not know psychiatric patients in this area, we only know
those who are on treatment and sometimes they default and can be traced and put back on treatment. Some of those who do not come at all, we are assisted by the CHW and report them, and then they are traced and get history from the relatives and take them to the doctor and put them back to treatment.

3. Relatives that are not supportive or co-operative, we send CHW to call them for us so that we are able to do health education to them about the condition as a whole and encourage them to be supportive.

Researcher : 3. What skills do you think are necessary for integration of services?
Participant : Patients become impatient some times because the clinic is full all patients come at the same time.

Researcher : Please describe your efforts in overcoming the integration consequences?
Participants : We consult with our patients and we help them as quickly as we can we also educate them to be patient especially the days when we are short staffed.

Researcher : 4. Describe if there has been a need to counsel users?
Participant : There is a need to always counsel our clients. For Instance one of the patients came to the clinic and took out a knife, then we called the security who is also a female, and we tried to talk to him
counselling him, then he left with that knife. We notified community members to be aware and we called the police then he was transferred to Komani hospital via Frontier hospital.
INTERVIEW No: 6 (Supervisor)

Community Psychiatric Nurses

Date: 13\textsuperscript{th} 04. 2011

Starting time : 11h00

Finishing time : 11h25

Total time : 25 minutes

PART A

Demographic Data:

Age

24 – 29 years

30 – 60 years \textbf{x}

Marital Status

Single

Married \textbf{x}

Other specify

Gender

Male

Female \textbf{x}

Period of employment

1 to 2 years
PART B: INTERVIEW

Researcher : 1. How would you describe your supervisory experience of newly qualified professional nurses in terms of their performance on specific procedures?

Participant : People are unique, their performance differs, some through mentoring they perform well, others still need mentorship. we also identify their shortcoming and support them.

Researcher : Do you mentor newly qualified nurses?

Participant : Yes, when they come for community service, I always pair them with old staff members. Though sometimes it is difficult due to shortage but we do it, so as to grow them professionally.

Researcher : 2. Please describe your relations with the newly qualified professional nurses?

Participant : They are the same as other professionals, we have family like ties, Staff meetings and quality improvement meetings are held.

Researcher : Explain family like ties?

Participant : When it is the birthday for one staff member, we buy presents for R250.00 to give to the person and the card just to boost our spirits/ Morale.
INTERVIEW No: 7 (PN)

KOMANI HOSPITAL

Date: 13th 04. 2011
Starting time : 12h30
Finishing time : 12h55
Total time : 25 minutes

PART A

Demographic Data:
Age
24 – 29 years x
30 – 60 years

Marital Status
Single x
Married
Other specify

Gender
Male x
Female

Period of employment
1 to 2 years
PART B: INTERVIEW

Researcher : 1. How would you describe your interpersonal experiences in caring for a mental health care user.

Participant : I experienced that these people are the same as other people, its only worse when the person has relapsed. Once they are on treatment they stabilise & behave well. We almost nurse the same patients because they become controlled on treatment and they are discharged. They relapse out there and come back.

Researcher : What do you think contributes to or causes their relapse?

Participant : Some default treatment, some go back to use of substances.

Researcher : Are they prepared for discharge together with their families?

Participant : In pre – discharge ward they are prepared, educated on importance of compliance, families are also educated when they visit the patients or when they fetch the patient on discharge.

Researcher : Do you communicate with the clinic that is nearest to the patient and notify them of the discharge of the patient?

Participant : Yes we do, sometimes the discharge summary are referred to district office to be distributed in management meetings to various clinics.
Researcher : Do you conduct home visits where one can see and identify those problems?

Participant : We do not conduct home visits, its only the social worker who sometimes do home visits when the patient is about to be discharged.

Researcher : 2. Please describe your intervention to challenges that you have identified during your work as a professional nurse?

Participant : Staff shortage is the major problem as a result, sometimes one professional nurse has to run two wards at the same time. Re – admissions of almost the same patients. We also start activities for patients but cannot be sustained due to staff shortage and the rotation to other wards, it becomes better when we have students allocated to our units.

Researcher : Which activities are those?

Participant : For instance we started activity for adolescents like grouping them according to their conditions and their behaviour and abilities so that they can be able to carry out activities on the same level, but it never kicked off due to shortage and sudden rotation to other wards.

Researcher : Describe your problem solving skills in combating challenges (name them).
Participant: 1. Lack of patients clothing – patients do not have clothing, there is no way of solving it because it has been reported to our supervisors and the old staff states that they gave up the request.

2. There is also a problem with the tendering company because food is outsourced and the diet is not good and there is no place where can raise these complaints.

3. Patients dignity is not promoted, e.g. there are no toothpaste for months or toilet rolls. There is shortage of wheelchairs, no physical training or occupational therapy here at Komani. There is nothing that is done because staff members are afraid of the Chief Executive Officer (CEO).

Researcher: 3. What skills do you think are necessary for integration of services?

Participants: We apply holistic approach to our patients.

Researcher: 4. Describe if there has been a need to counsel users?

Participant: There is a need to counsel them, others they are HIV positive, we need to talk to them. Other patient get visitation by their relatives and those who are not visited become hurt and regress when they see the parcels of the visited patients, so we do counsel them.
INTERVIEW No: 8 (PN)
KOMANI HOSPITAL

Date: 13th 04. 2011
Starting time : 14h00
Finishing time : 14h25
Total time : 25 minutes

PART A

Demographic Data:

Age
24 – 29 years
30 – 60 years  x

Marital Status

Single
Married  x
Other specify

Gender

Male
Female  x

Period of employment

1 to 2 years
3 to 5 years  x
5 years and more

PART B: INTERVIEW

Researcher : 1. How would you describe your interpersonal experiences in caring for mental health care users?

Participant : Patients need to be treated like human beings not to be discriminated about their conditions. They need to be loved, and belong and be cared for. One must monitor that they take their treatment to minimise relapse rate. Also nurse - patient relationship needs to be maintained so that they are all treated the same and equally.

Researcher : Do you conduct home visits where one is able to monitor compliance issues?

Participant : We do not conduct home visits.

Researcher : 2. Please describe your intervention to challenges that you have identified during your work as a professional nurse?

Participant : Number one our wards are different, when one starts to be familiar with the ward with its patients, one is moved to another ward. Sometimes it becomes difficult to do ward activities because one finds out that others are able to do activities and others cannot, they need to be assisted fully e.g. bedridden patients. Resources are inadequate, patients abscond and windows in domatories are
broken and not repaired.

Researcher: Which activities are those?

Participant: Like playing cards or singing.

Researcher: Describe your problem solving skills in combating challenges (name them).

Participant: 1. There is staff shortage, it is known by the supervisors.

2. Many problems pertains to patients e.g. no hot water, they wash with cold water, no clothing and they end up having lice, and diet is not good. There is no way of solving these problems because these are reported and known by management.

Researcher: 3. What skills do you think are necessary for integration of services?

Participants: We do holistic approach, there are no integration problems.

Researcher: 4. Describe if there has been a need to counsel users?

Participant: Not really especially when one is working in ward like this (ID ward).
Date: 13\textsuperscript{th} 04. 2011

Starting time : 14h30

Finishing time : 14h55

Total time : 25 minutes

PART A

Demographic Data:

Age

24 – 29 years

30 – 60 years \(x\)

Marital Status

Single

Married \(x\)

Other specify

Gender

Male

Female \(x\)

Period of employment
PART B: INTERVIEW

Researcher : 1. How would you describe your supervisory experience of newly qualified professional nurses in terms of their performance on specific procedures?

Participant : We orientate them and get feedback from them, also we observe if they are carrying out the tasks you discussed during orientation and if not one re – orientate, but most of them are performing.

Researcher : 2. Please describe your relations with the newly qualified professional nurses?

Participant : Relations are good, they carry out the delegated tasks. If there are problems we sit down and sort the out.

Researcher : Which problems?

Participant : Like strangled relations amongst staff members, then I call a meeting With those staff members and discuss the matter further.
University of Fort Hare

Ethics Committee

Sir /Madam

Application: Permission to conduct research study

I am a student challenging M(cur) degree at the University of Fort Hare.

I wish to humbly request permission to conduct a research study on the evaluation on the performance of newly qualified professional nurses in psychiatric care services. This study is aimed at identifying the challenges that are posed by the curriculum and the care rendered by the new professional nurse.

Hoping that my request will receive your prompt attention.

Yours faithfully

L. H. Zonke  
Mcur Student (UFH)

Supervisor Signature  
__________________________
Nursing Director
Department of Health
Eastern Cape Province
Sir/Madam

Request for permission to conduct research study

I wish to humbly request permission to conduct a research study on the evaluation of the performance of newly qualified professional nurses in psychiatric care services. This study is aimed at identifying the challenges posed by the curriculum and the care rendered by the new professional nurse. The study is also in fulfillment of a Masters Degree under the Department of Nursing Science of the University of Fort Hare.

The study will not be time consuming, it will take about 15 minutes to answer the interview guide. The interview guide will be made available on request, but will remain the property of the university. Research findings will be compiled and recommendations will be forwarded to your office.

Hoping that my request will receive your prompt attention.

Yours faithfully

L. H. Zonke [Mcur Student (UFH)] Supervisor Signature ---------------------------
The District Manager
Department of Health
Chris Hani District
Sir /Madam

Request for permission to conduct research study

I wish to humbly request permission to conduct a research study on the evaluation of the performance of newly qualified professional nurses in psychiatric care services. This study is aimed at identifying the challenges posed by the curriculum and the care rendered by the new professional nurse. The study is also in fulfillment of a Masters Degree under the Department of Nursing Science of the University of Fort Hare.

The study will not be time consuming, it will take about 15 minutes to answer the interview guide. The interview guide will be made available on request, but will remain the property of the university.

Research findings will be compiled and recommendations, forwarded to your office.

Hoping that my request will receive your prompt attention.

Yours faithfully

L. H. Zonke  Supervisor Signature  --------------------------

Mcur Student (UFH)
I am Lulama Zonke, studying for a master’s degree with the University of Fort Hare. My research study is on “evaluation of the performance of newly qualified professional nurses in psychiatric care services”. The study will be in the form of individual interviews and sessions will take a maximum of 30 minutes.

The answers will be recorded on the interview guide form. Your name will not be written on the interview form and no one will be able to link you to the answers. You are free to withdraw from the study at any point even if the interview is not completed. The study may raise psychological stress but support will be provided throughout the interview and when the need arises.

It also needs to be clarified that participating in this research can benefit the participant in various ways:

- Identifying gaps in rendered care will enhance professional development
- Observing all systems in place in psychiatric institutions e.g. multidisciplinary team, will promote quality care to our communities.
- Identifying challenges that inhibit promotion of mental health care to the society and users, and de - stigmatisation of mental illness may be the direction to finding solution.

Summary of the findings will be made available to you on request, if there are any questions or queries during the process of the study do not hesitate to contact the researcher at 083 857 5897

I ____________________________ hereby agree to participate in a research study regarding evaluation of the performance of newly qualified professional nurses in psychiatric care services. I understand that I am participating freely and with no any obligations. I understand that this consent will not be linked to the interview form and my answers will remain confidential.

Signature of participant ---------------------------- Date --------------------------
GROUPING OF SIMILAR PHRASES

1. EXPERIENCE:

INTERVIEW 1:
- Not much experience at work.
- Learning not taking place i.e. clients are only coming for repeat of medication.
- Emphasize compliance - imparting knowledge to clients

INTERVIEW 2:
- Imparting knowledge to clients – encouraging compliance.

INTERVIEW 4:
- Wide experiences –using skills.
- Imparting knowledge to users & relatives.
- Encourage compliance.
- Accepting users and are supportive of them.
- Projects/ activities are planned for clients

INTERVIEW 5:
- Patients are manipulative
- Clients have bad attitudes towards others and towards staff.
- Nurses impart knowledge.

INTERVIEW 7:
- Users are the same as other normal people (effectiveness of treatment)
- Users abuse substances and default treatment.
- Compliance encouraged – imparting knowledge to clients

INTERVIEW 8:
- Humanity practices.
- Compliance encouraged.
- Clients treated equally.

2. STAFFING:

INTERVIEW 1:
• Shortage of staff
• Increased workload
• Focusing at curative work at the clinic

INTERVIEW 2:
• Pressure of work.
• Increased workload.
• Staff shortage.

INTERVIEW 4:
• Pressure of work
• Increased workload
• Shortage of staff
• Users continue with projects without assistance

INTERVIEW 5:
• Shortage of staff
• Clients continue with projects on their own.
• No continuity of programmes.

INTERVIEW 7:
• Shortage of staff
• No sustainability or continuity of projects.
• Frequent rotation of staff
• No freedom of speech.

INTERVIEW 8:
• Frequent rotation of staff
• Shortage of staff

3. OUTREACH PROGRAMMES:

INTERVIEW 1:
• Outreach programme done by CHW.
• Occasionally by Professional nurses.
• Primary prevention done by CHW.
INTERVIEW 2:

- Primary prevention done by CHW.

INTERVIEW 4:

- Primary prevention done by CHW.

INTERVIEW 5:

- Primary prevention done by CHW.

INTERVIEW 7:

- No outreach programmes in hospital situation.

INTERVIEW 8:

- No outreach programmes in hospital situation.

4. ACTIVITIES BY CHW:

INTERVIEW 1:

- Home visits.
- Monitoring clients treatment intake
- Trace defaulters.
- Health Education

INTERVIEW 2:

- Home visits
- Follow ups occasionally by Professional Nurses.
- Tracing defaulters

INTERVIEW 4:

- CHW conducting home visits.
- Tracing defaulters
- Monitor treatment for clients
- Calling relatives of patients to clinics

INTERVIEW 5:

- CHW conducting home visits
• Tracing defaulters
• Monitor treatment of clients
• Calling relatives of clients to the clinic

INTERVIEW 7:
No community health workers in hospital situation.

INTERVIEW 8:
• No community health workers in hospital situation.

5. DUTIES OF PSYCHIATRIC PROFESSIONAL NURSES:

INTERVIEW 1:
• Health Education
• Organise awareness functions
• Curative work
• Referrals of patients
• Counselling of patients
• Supporting clients.

INTERVIEW 2:
• Health education
• PN occasionally do follow up visits
• Ordering of resources e.g. medication
• Supporting users.
• Collaboration with supervisors

INTERVIEW 4:
• Doing activities for users.
• Supporting users
• Health education
• Establishing support groups
• Doing curative work in clinics.

INTERVIEW 5:
• Referrals
• Collaboration with family members
• Supportive to users.

INTERVIEW 7:
• Health education
• Discharge preparation of patients.
• Holistic approach
• Supportive to users.

INTERVIEW 8:
• Health education
• Collaboration with hospital management
• Holistic approach
• Counselling.

6. CHALLENGES IDENTIFIED BY THE PSYCHIATRIC PROFESSIONAL NURSE:

INTERVIEW 1:
• Staff shortage
• No outreach programmes done by PPN
• Pressure of work
• Lack of proper skills e.g. VCT not equipped
• Inefficiency due to lack of resources.
• Pts not treated in totality
• Lack of support of users by family members.

INTERVIEW 2:
• Family members not supportive of users.
• Shortage of staff.
• Increased workload
• Shortage of resources e.g. medication
• Poor communication between institution and clinics.

INTERVIEW 4:
• No continuity of activities due to shortage
• Shortage of staff
• No psychiatrist at clinics
• Shortage of resources
• Lack of continuity of care – no multidisciplinary team at community level.
• Doing VCT to users.

INTERVIEW 5:

• Shortage of staff
• Lack of continuity of activities
• Family members not supportive of users
• Shortage of resources.
• Relatives not supportive to users

INTERVIEW 7:

• Substance abuse by patients on treatment
• Shortage of staff
• No continuity of activities
• Lack of patient clothing
• Poor diet of patients
• Patient dignity not maintained
• No freedom of speech

INTERVIEW 8:

• Frequent rotation of staff
• Lack of resources.
• Bad conditions of the hospital
• Shortage of staff
• No clothing for patients
• Patients have lice
• Poor diet
• No resolution of problems

7. WHAT CAN BE SAID ABOUT INTEGRATION:

INTERVIEW 1:

• Lack of proper skills development e.g. VCT not equipped
• Patients not treated in totality
• Pressure of work
• Lack of resources
• Shortage of staff.
INTERVIEW 2:

- Health education not done fully – it is time consuming
- Shortage of staff
- Pressure of work / Increased workload
- Shortage of resource e.g. medication

INTERVIEW 4:

- No continuity of activities
- Shortage of staff
- No psychiatrist at clinics
- Shortage of resources

INTERVIEW 5:

- Shortage of staff
- Lack continuity of activities
- Shortage of resources
- Relatives not supportive
- Patients become impatient in long queues.

INTERVIEW 7:

- Shortage of staff
- Frequent rotation

INTERVIEW 8:

- Frequent rotation of staff
- Lack of resources
- Shortage of staff

8. NEED FOR COUNSELLING:

INTERVIEW 1:

- There is a need to counsel users
- Support of patients done by PNs.

INTERVIEW 2:

- Support given to users
There is a need to counsel users

INTERVIEW 4:

- Support given to users
- There is a need to counsel them

INTERVIEW 5:

- Patients supported by staff members

INTERVIEW 7:

- Users supported by staff.

INTERVIEW 8:

- Users not counselled - they have Intellectual Disability.
**APPENDIX: G**

The development of themes:

Community Psychiatric Nurses

<table>
<thead>
<tr>
<th>LEVEL 1 (interview 1)</th>
<th>INTERVIEW CONTENT</th>
<th>LEVEL 11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less to learn</td>
<td>Line 1 – there is not much experience</td>
<td>Learning not taking place at work</td>
</tr>
<tr>
<td>Emphasize compliance</td>
<td>Line 2 – health education on compliance</td>
<td>Compliance encouraged.</td>
</tr>
<tr>
<td>Objective data gathered</td>
<td>Line 4 nurse must be observant so that she can be able to assess and diagnose</td>
<td>Imparting knowledge</td>
</tr>
<tr>
<td>Short staffed</td>
<td>Line 7 &amp; 8 – no time Patients waiting outside to be attended</td>
<td>There is staff shortage and increased workload</td>
</tr>
<tr>
<td>Pressure of work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No outreach programmes</td>
<td>Line 11 – Only CHW who go out</td>
<td>Primary prevention done by CHW, PN doing curative work at the clinic</td>
</tr>
<tr>
<td>done by professional</td>
<td></td>
<td></td>
</tr>
<tr>
<td>nurses (PN) only done</td>
<td></td>
<td></td>
</tr>
<tr>
<td>by CHW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Awareness functions</td>
<td>Line 13 – organise and do functions like awareness on substance abuse</td>
<td>Prevention of mental illness done when there is organised occasion.</td>
</tr>
<tr>
<td>organised</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHW relieves PNs in</td>
<td>Line 16 – they do home visits, monitor treatment intake dosage and all.</td>
<td>Primary prevention done by CHW.</td>
</tr>
<tr>
<td>home visits, monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>of treatment intake</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and dosages.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shortage of resources</td>
<td>Line 22 – There is shortage of resources</td>
<td>There is shortage of resources.</td>
</tr>
<tr>
<td>e.g. medicine &amp;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>equipment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Issue</td>
<td>Line</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Inefficiency due to lack of resources</td>
<td>24</td>
<td>There is shortage of resources</td>
</tr>
<tr>
<td>Lack of proper skills development</td>
<td>27</td>
<td>There is also lack of proper skills development</td>
</tr>
<tr>
<td>VCT not equipped</td>
<td>30</td>
<td>Patients need to be done VCT but we have to refer</td>
</tr>
<tr>
<td>Patients not treated in totality</td>
<td>29</td>
<td>This does not enable one to treat the patient in totality</td>
</tr>
<tr>
<td>Patients defaulting treatment are traced by CHW.</td>
<td>30</td>
<td>We normally send CHW to trace defaulters.</td>
</tr>
<tr>
<td>Poverty causes medication to be defaulted</td>
<td>32</td>
<td>Poverty – clients complaining of unemployment &amp; cannot take food on an empty stomach.</td>
</tr>
<tr>
<td>Sending patients to local doctor for assessments for disability grant &amp; social development for food parcels</td>
<td>34</td>
<td>Patients sent to the local doctor for assessment for disability grant and social development for food parcels.</td>
</tr>
<tr>
<td>Lack of support from family members</td>
<td>35</td>
<td>Relatives not taking care of their immediate families.</td>
</tr>
<tr>
<td>Lists made for skills development</td>
<td>38</td>
<td>We have communicated with our supervisors about the problem and have taken our names to the skills development person.</td>
</tr>
<tr>
<td>Pressure of work</td>
<td>40</td>
<td>All patients come at the same time to the clinic and they all want to be assisted.</td>
</tr>
<tr>
<td>Patients exhibit manipulative behaviour</td>
<td>44</td>
<td>Some are manipulative but if you explain to them they</td>
</tr>
</tbody>
</table>
Mental health care users demand to be respected

- Line 47 – They only want one to show respect to them.
- Mental health care users also need to be respected

There is a need to counsel users.

- Line 50 – There has been a need to counsel users
- Imparting knowledge by counselling the users

Health education on side effects and on management.

- Line 51 – Also educate them about side effects and how to manage them.
- Imparting knowledge by educating users about side effects.

Supporting the patient

- Line 52 – Even if he / she is in institution you support him / her to have hope and continue with medication
- Staff members are supportive of users.

NB: (...) is an ellipsis and symbolises missing text.

<table>
<thead>
<tr>
<th>LEVEL 1(interview 2)</th>
<th>INTRVIEW CONTENT</th>
<th>LEVEL 11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance to treatment</td>
<td>Line 3- To make sure that patient is adhering to treatment...</td>
<td>Compliance to treatment / Healthy living with mental illness.</td>
</tr>
<tr>
<td>Health promotion /education</td>
<td>Line 8 – we do give health education on importance of compliance...</td>
<td>Health promotion to clients and relatives.</td>
</tr>
<tr>
<td>Home visits</td>
<td>Line19 – home visits are done by CHW</td>
<td>Health promotion to clients and relatives.</td>
</tr>
<tr>
<td>Undermining of CHW by clients.</td>
<td>Line 22 –When the clients have defaulted, they go and trace them but in cases where there is a need for a professional nurse we do go e.g. when a patient is belittling the</td>
<td>Poor judgement of CHW</td>
</tr>
</tbody>
</table>
## CHW

<table>
<thead>
<tr>
<th>Shortage of drugs</th>
<th>Line 31 – shortage of drugs / medication also poses a problem</th>
<th>Material resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>No feedbacks on referrals</td>
<td>Line 32 – when we refer patients to second level of care...</td>
<td>No feedback on referrals</td>
</tr>
<tr>
<td>Incomplete communication amongst health care workers</td>
<td>Line 40 – We did communicate these problems with our supervisors, and they promised to communicate it further to their management meetings so as to improve...</td>
<td>Poor communication amongst employer and employees</td>
</tr>
<tr>
<td>Sorting of patients</td>
<td>Line 62 – patients are no longer coming on different days for their treatments or minor ailments due to integration and want to...</td>
<td>Triaging</td>
</tr>
<tr>
<td>Prioritising clients according to their level of illness / stability</td>
<td>Line 67 – we normally request other clients in queue to allow us to start with...</td>
<td>Triaging</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LEVEL 1(interview 4)</th>
<th>INTERVIEW CONTENT</th>
<th>LEVEL 11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warm welcome of clients</td>
<td>Line 3 – come closer to them, motivate them, we need not to judge them</td>
<td>Good reception of clients Avoidance of judgemental attitudes(Batho Pele principle 1)</td>
</tr>
<tr>
<td>Rehabilitation programmes</td>
<td>Line 9 – They have gardening project, some of them participate in cleaning the outside</td>
<td>Rehabilitation programmes are working well</td>
</tr>
<tr>
<td>Environment</td>
<td>Compliance to treatments</td>
<td>Ensure compliance to treatment, facilitation of support groups</td>
</tr>
<tr>
<td>-------------</td>
<td>---------------------------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Line 11 – they also have</td>
<td></td>
</tr>
<tr>
<td></td>
<td>support group comply with</td>
<td></td>
</tr>
<tr>
<td></td>
<td>treatment...</td>
<td></td>
</tr>
<tr>
<td>Well established supportive groups</td>
<td>Line 16 – support groups are held on Thursdays...</td>
<td>Facilitation of support groups</td>
</tr>
<tr>
<td>Working independently</td>
<td>Line 17 – no longer assisting them due to shortage of staff...</td>
<td>Show signs of independence / effectiveness of treatment</td>
</tr>
<tr>
<td>Shortage of medication / delay in treatment supply</td>
<td>Line 23 – some patients come for repeat of treatment, when out of stock we refer them to Komani hosp...</td>
<td>Lack of material resources such as medication / inconvenience to clients e.g. travels costs.</td>
</tr>
<tr>
<td>No multidisciplinary approach at primary level</td>
<td>Line 28 – no at community level we do not have the multidisciplinary team...</td>
<td>Multidisciplinary approach not practised at first level of care</td>
</tr>
<tr>
<td>Follow up treatments at home</td>
<td>Line 30– no its CHW who do home visits</td>
<td>No home visits done by PNs</td>
</tr>
<tr>
<td>Tracing defaulters</td>
<td>Line 33 – they assist us by tracing defaulters..., they also report noncompliance.</td>
<td>Community observed treatments / Dot supporters</td>
</tr>
<tr>
<td>Health education</td>
<td>Line 36 – they also help with health education</td>
<td>Promotion of health education.</td>
</tr>
<tr>
<td>Misidentification of clients / Medication errors</td>
<td>Line 39 – Clients discharged from Komani hospital with wrong medication</td>
<td>Medication errors results in delayed treatment</td>
</tr>
<tr>
<td>HIV pandemic / clients need to be counselled for</td>
<td>Line 43 – It becomes a problem when identifies</td>
<td>HIV counselling is essential</td>
</tr>
<tr>
<td>HIV.</td>
<td>Integration hindered by staff shortage</td>
<td>Improper care</td>
</tr>
<tr>
<td>------</td>
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<td>---------------</td>
</tr>
<tr>
<td>that HIV counselling (VCT) needs to be done</td>
<td>Line 54 – The problem arises when staff members are off because we become short staffed...</td>
<td>Line 64 – Sometimes family members complain that there is improper care at Komani hospital.... because their family members absconded</td>
</tr>
<tr>
<td>Human resource shortages</td>
<td>Poor service delivery</td>
<td>Family support / involvement</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LEVEL 1 (interview 5)</th>
<th>INTERVIEW CONTENT</th>
<th>LEVEL 11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification of manipulative behaviour of clients</td>
<td>Line 3 – users are very manipulative</td>
<td>Manipulative behaviour</td>
</tr>
<tr>
<td>Home visits</td>
<td>Line 15 – CHW are doing home visits</td>
<td>Follow up care</td>
</tr>
<tr>
<td>Clients bad attitude</td>
<td>Line 25 – Some clients have bad attitudes, they come to clinic for first time and...</td>
<td>Clients bad attitude /negative attitude about reception / services</td>
</tr>
<tr>
<td>Tracing defaulters</td>
<td>Line 17 – they help us to trace the defaulters especially when we have...</td>
<td>Identification of treatment defaulters</td>
</tr>
<tr>
<td>Health education to communities</td>
<td>Line 19 – they do health education to our communities...</td>
<td>Knowledge expansion to communities</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>--------------------------------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Clients’ attitudes</td>
<td>Line 24 – some clients have bad attitudes...</td>
<td>Clients’ attitudes</td>
</tr>
<tr>
<td>Human resource shortages</td>
<td>Line 27 – We also have shortage of staff as a result we cannot continue…</td>
<td>Human resource shortages</td>
</tr>
<tr>
<td>Programmes not finished</td>
<td>Line 27 - we cannot continue with programmes...</td>
<td>Poor project / programme management.</td>
</tr>
<tr>
<td>Self-help / work independently</td>
<td>Line 30 – but our client continue with it on their own</td>
<td>Self help</td>
</tr>
<tr>
<td>Poor family support</td>
<td>Line 44 – Relatives that are not supportive or co-operative...</td>
<td>Poor family support</td>
</tr>
<tr>
<td>Waiting time</td>
<td>Line 49 – patients become impatient some times because the clinic is full...</td>
<td>Mapping of services</td>
</tr>
<tr>
<td>Explanation to clients</td>
<td>Line 53 – We consult with our clients and we help them as quickly as we can</td>
<td>Redress / consultation</td>
</tr>
</tbody>
</table>

**Hospital Services**

<table>
<thead>
<tr>
<th>LEVEL 1 (interview 7)</th>
<th>INTERVIEW CONTENT</th>
<th>LEVEL 11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective treatment</td>
<td>Line 3 – I experienced that these people are the same as other people</td>
<td>Effectiveness of medication</td>
</tr>
<tr>
<td>Topic</td>
<td>Line</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Well controlled with treatment</td>
<td>Line 4</td>
<td>once they are on treatment, they stabilise and behave.</td>
</tr>
<tr>
<td>Stressors at home</td>
<td>Line 7</td>
<td>they relapse out there and come back</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>Line 9</td>
<td>Some default treatment, some go back to use substances</td>
</tr>
<tr>
<td>Health education to both clients and families</td>
<td>Line 11</td>
<td>in pre – discharge they are educated on importance of compliance.</td>
</tr>
<tr>
<td>Communication with clinics</td>
<td>Line 16</td>
<td>we do communicate, sometimes discharge summaries are sent to district office</td>
</tr>
<tr>
<td>Shortage of staff</td>
<td>Line 26</td>
<td>shortage of staff is a major problem</td>
</tr>
<tr>
<td>No sustainability or continuity of activities</td>
<td>Line 28</td>
<td>we also start activities for patients but cannot be sustained</td>
</tr>
<tr>
<td>Frequent rotation of staff</td>
<td>Line 35</td>
<td>sudden rotation to other wards</td>
</tr>
<tr>
<td>Lack of patient clothing</td>
<td>Line 37</td>
<td>patients do not have clothing</td>
</tr>
<tr>
<td>Poor diet</td>
<td>Line 41</td>
<td>diet is not good</td>
</tr>
<tr>
<td>Patients dignity not promoted</td>
<td>Line 43</td>
<td>patient dignity not promoted</td>
</tr>
<tr>
<td>No freedom of speech</td>
<td>Line 46</td>
<td>staff members are afraid of the chief</td>
</tr>
<tr>
<td>EVEL 1(interview 8)</td>
<td>INTERVIEW CONTENT</td>
<td>LEVEL 11</td>
</tr>
<tr>
<td>-------------------</td>
<td>------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Holistic approach</td>
<td>Line 49 – we apply holistic approach</td>
<td>Holistic approach promoted</td>
</tr>
<tr>
<td>Users are supported by staff</td>
<td>Line 51 – there is a need to counsel them</td>
<td>Users are supported</td>
</tr>
<tr>
<td>Humanity</td>
<td>Line 3 – Patients need to be treated like human beings</td>
<td>Humanity practises</td>
</tr>
<tr>
<td>Ensuring compliance</td>
<td>Line 5 – One must monitor that they take their treatment to minimise relapse rate</td>
<td>Compliance promoted</td>
</tr>
<tr>
<td>Equality</td>
<td>Line 7 – they are all treated the same and equally</td>
<td>Patient treated equally</td>
</tr>
<tr>
<td>Home visits not done</td>
<td>Line 10 – we do not conduct home visits</td>
<td>Home visits not done</td>
</tr>
<tr>
<td>Frequent rotation of staff</td>
<td>Line 13 – when one starts to be familiar with the ward, one is moved to another ward</td>
<td>Frequent rotation of staff</td>
</tr>
<tr>
<td>Lack of resources</td>
<td>Line 17 – resources are inadequate</td>
<td>Lack / shortage of resources</td>
</tr>
<tr>
<td>Bad conditions of the hospital</td>
<td>Line 18 – patients abscond and windows in dormitories are broken and not repaired</td>
<td>Bad conditions of the hospital</td>
</tr>
<tr>
<td>Shortage of staff</td>
<td>Line 23 – there is staff</td>
<td>Shortage of staff</td>
</tr>
<tr>
<td>Shortage</td>
<td>Line 24 – many problems pertains to patients e.g. no hot water, they wash with cold water</td>
<td>Bad conditions of the hospital</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>No clothing for patients</td>
<td>Line 25 – no clothing</td>
<td>Dignity violation</td>
</tr>
<tr>
<td>Patients have lice</td>
<td>Line 25 – end up having lice</td>
<td>Dignity violation</td>
</tr>
<tr>
<td>Poor diet</td>
<td>Line 26 – and the diet is not good</td>
<td>Poor diet</td>
</tr>
<tr>
<td>No resolution of problems &amp; known by management</td>
<td>Line 26 -27 – there is no way of solving these problems because these are reported &amp; known by the management</td>
<td>No resolution of problems / no freedom of speech</td>
</tr>
<tr>
<td>Holistic approach is done</td>
<td>Line 30 – we do holistic approach</td>
<td>Holistic approach done</td>
</tr>
<tr>
<td>Users not counselled i.e. intellectual disabled patients</td>
<td>Line 32 – not really especially when one is working in ward like intellectual disable ward</td>
<td>Users not counselled especially in the intellectual disabled patients.</td>
</tr>
</tbody>
</table>

**Supervisor Interviews**

Community Psychiatric Services

<table>
<thead>
<tr>
<th>LEVEL 1 (interview 3)</th>
<th>INTERVIEW CONTENT</th>
<th>LEVEL 11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newly qualified professional nurses performing well and are co-operative</td>
<td>Line 4 – they are performing well and are very much co-operative</td>
<td>Good performance</td>
</tr>
<tr>
<td>They seek for help and knowledge</td>
<td>Line 5 – what I like is that if they do not understand they ask, and they</td>
<td>Assertiveness / pro-activeness</td>
</tr>
</tbody>
</table>
are always attended to.

<table>
<thead>
<tr>
<th>No complaints</th>
<th>Line 8 – with the nurses we have, we are not complaining</th>
<th>Supervisors not complaining</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delegated tasks carried out well &amp; co-operative</td>
<td>Line 8 – 9 – they carry out their delegated tasks well</td>
<td>Competence</td>
</tr>
<tr>
<td>Good relations experienced</td>
<td>Line 12 – we have good relations</td>
<td>Good interpersonal relations experienced</td>
</tr>
<tr>
<td>Co-operation</td>
<td>Line 12 – they are very much co-operative</td>
<td>Co-operation experienced</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LEVEL 1 (interview 6)</th>
<th>INTERVIEW CONTENT</th>
<th>LEVEL 11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mentoring of nurses</td>
<td>Line 4 – some through mentoring they perform well</td>
<td>Mentoring of nurses / Individualism / uniqueness</td>
</tr>
<tr>
<td>Support of Professional nurses</td>
<td>Line 6 – identify their shortcomings and support them</td>
<td>/ Filling of knowledge gap</td>
</tr>
<tr>
<td>Acceptance</td>
<td>Line 8 – I always pair them with old staff members</td>
<td>Continuous mentorship e.g. guidance or coaching</td>
</tr>
<tr>
<td>No discriminations</td>
<td>Line 13 they are the same as other professionals</td>
<td>Acceptance</td>
</tr>
<tr>
<td>Togetherness</td>
<td>Line 16 – when it is a birthday for one staff member, we buy presents</td>
<td>Strengthening social ties / motivation / improve morale</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LEVEL 1 (interview 9)</th>
<th>INTERVIEW CONTENT</th>
<th>LEVEL 11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orientation done</td>
<td>Line 4 – we orientate &amp; get feedback from them</td>
<td>Feedback</td>
</tr>
<tr>
<td>Performance is good</td>
<td>Line 6 – most of them are performing</td>
<td>Good performance of newly qualified professional nurses</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>Good relations</td>
<td>Line 8 – relations are good</td>
<td>Good relations</td>
</tr>
<tr>
<td>Good performance</td>
<td>Line 8 – they carry out delegated tasks</td>
<td>Good performance</td>
</tr>
<tr>
<td>Staff problems solved</td>
<td>Line 11 – if there are strangled relations between staff members, then I call a meeting with those members and discuss the matter further</td>
<td>Problem solving</td>
</tr>
</tbody>
</table>