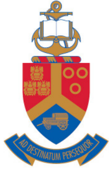

Faculty of Health Sciences

RESEARCH DISSERTATION

GUIDELINES FOR PSYCHIATRIC NURSES TAKING CARE OF MENTAL HEALTH CARE USERS LIVING WITH HIV AND AIDS IN A PUBLIC PSYCHIATRIC HOSPITAL

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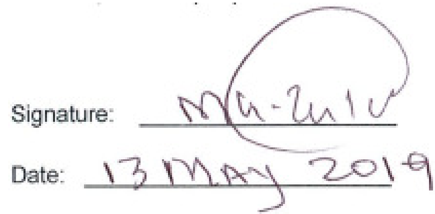
MAY 2019

DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced



ABSTRACT

Considering the growing consensus surrounding the need for psychiatric nurses taking care of mental health-care users living with HIV/AIDS, this study is about guidelines for psychiatric nurses caring for mental health-care users living with HIV/AIDS in a public psychiatric hospital. In this regard, the study critically explored the extent to which psychiatric nurses are providing care to these users in a public psychiatric hospital. It did so by firstly exploring and describing psychiatric nurse experiences of providing care to mental health care users living with HIV and AIDS in a public psychiatric hospital in Gauteng. Secondly, to the researcher developed guidelines for nursing management based on psychiatric nurses' experiences to ensure effective care to mental health care users living with HIV and AIDS.

An explorative, descriptive, contextual and qualitative design was used to explore and describe nurses' experiences. Purposive sampling was used to select nine participants. Data were collected using interviews and analysed using thematic analysis. The guidelines were derived from the findings and validated using a Delphi technique and, subsequently, measure to ensure trustworthiness were followed. Ethical considerations were observed to ensure no harm was done, participants' confidentiality was ensured, and informed consent was obtained.

The findings were gathered into four main clusters that logically belonged together. These four clusters were: These four clusters were: 1) issues related to psychiatric nurses caring for MHCUs living with HIV/AIDS; 2) issues related to MHCUs living with HIV/AIDS; 3) ways of coping of psychiatric nurses caring for MHCUs living with HIV/AIDS; and 4) psychiatric nurses' need for support in caring for MHCUs living with HIV/AIDS. From *cluster 1* two guidelines were derived, from *cluster 2* two guidelines, from *cluster 3* one guideline, and from *cluster 4* two guidelines were derived. A one-round Delphi technique was used to validate the guidelines to ensure effective care to to mental health care users living with HIV and AIDS. This dissertation provides recommendations to implement the guidelines for psychiatric nurses taking care of mental health care users in a psychiatric hospital.

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ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
HIV	Human immunodeficiency virus
MHCU	Mental health care user
WHO	World Health Organization

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CHAPTER 1: OVERVIEW OF THE STUDY

1.1 INTRODUCTION

During practice psychiatric nurses may encounter mental health-care users (MHCUs) living with human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS). The care of MHCUs living with HIV and AIDS has been identified by the researcher as a challenge facing psychiatric nurses. The challenges are related to the physical exposure to and risk of infection caused by MHCUs' violent behaviour, and coping with the human suffering associated with HIV and AIDS such as stigma and discrimination (Sowell & Phillips, 2010: 394). HIV care for MHCUs should be a priority for researchers, health-care providers and policy makers. There are no clear guidelines for clinicians when treating MHCUs with co-morbid HIV and mental illness. There is a need for evidence-based guidelines (Hobkirk, Towe, Lion & Meade, 2015: 406).

According to the Mental Health Care Act (no. 17 of 2002), inpatient psychiatric care can be provided on a voluntary or involuntary basis. Voluntary admission takes place when individuals observe themselves to have mental health problems and seek professional help, while involuntary admissions happen when individuals, who despite needing help, refuse such treatment. Involuntary admissions are done to protect both the MHCU and the society as the MHCU could be a danger to self and/or others. Psychiatric nurses are required to care for involuntary MHCUs with potential violent behaviors, which expose psychiatric nurses to the danger of being physically assaulted and exposed to the HIV virus. According to Bimenyimana, Poggenpoel, Myburg and Van Niekerk (2009: 1) psychiatric nurses tend to be subjected to physical assault from MHCUs, such as being slapped, hit or bitten.

The psychiatric hospital where the research was conducted admits MHCUs diagnosed with anxiety, mood, psychotic, eating, cognitive, substance-induced and conduct disorders. In the acute care environment where treatment is provided for MHCUs with acute psychiatric symptoms and substance withdrawal symptoms, MHCUs often respond with aggressive behaviour. According to the researcher's experience as a psychiatric nurse, psychiatric nurses often experience violent incidents during their interventions with MHCUs, which might lead to contamination with body fluids. This adds to the complexities of health-care provision to

MHCUs living with HIV and AIDS which poses challenges to psychiatric nurses and nursing management.

1.2 BACKGROUND

The United Nations Programme on HIV/AIDS (Joint United Nations Programme on HIV/AIDS, 2017: n.p) reported that worldwide an estimated 36.7 million people live with HIV/AIDS, while 1.8 million of them are under the age of 15. More than two thirds of all people living with HIV (25.5 million), live in sub-Saharan Africa. South Africa represents a quarter of the burden of HIV infection in sub-Saharan Africa. While the estimated South African population is 56.52 million, the total number of people living with HIV was estimated at 5.24 million in 2016. HIV/AIDS was most prevalent in the South African province of Gauteng with a 12.6% prevalence rate, Kwazulu-Natal followed with 12.2%, Northern Cape with 6.8. % and Western Cape with 5.6% (Joint United Nations Programme on HIV/AIDS, 2017: n.p).

Mental health problems and HIV are closely interlinked; mental health problems are associated with increased risk of HIV infection and may interfere with treatment. MHCUs with HIV often have poor adherence to medication regimes, increasing their risk for poor outcomes which lead to treatment resistance and placing others at risk (Wu, Rothbard, Holtgrave & Blank, 2016: 439). An American study reported a prevalence rate of HIV among MHCUs of 5.9% in psychiatric inpatient units and 3.9% in community mental health centres. In African countries, where the national HIV prevalence tends to be higher than in America, rates ranged from 11% to 27% (Hobkirk, Towe, Lion & Meade, 2015: 406). Another American study reported an incidence of HIV among MHCUs of between 4% to 23% as compared to 4% to 6% in the general population over comparable time periods (Wu, Rothbard, Holtgrave & Blank, 2016: 439). Research done by Moore and Posada (2013: n.p) has shown an overlap between HIV infection and several major mental disorders such as major depressive disorder, bipolar disorder, substance related disorders and neuropsychological impairment. This finding was supported by a study done in South Africa (Henning, Kruger & Fletcher, 2012: 335) indicating that 23.8% of all psychiatric admissions were HIV positive. In Gauteng province 9% of 200 acute psychiatric admissions were HIV positive compared to 29.1% in Kwa Zulu Natal (Henning, Kruger & Fletcher, 2012: 335). There is an increase in hospitalisation of MHCUs

with HIV and AIDS in public psychiatric hospitals and in tertiary hospitals (Wu, Rothbard, Holtgrave & Blank, and 2016: 439).

Individuals with both mental illness and HIV represent a vulnerable and possibly growing segment of the HIV population. Mental illness can occur independently through risk related behaviour or can be a psychological consequence of HIV, for example, depression. Regardless of the causes of mental illness, it increases a person's risk of acquiring or transmitting HIV (Hobkirk, Towe, Lion & Meade, 2015: 406). MHCUs might be more vulnerable to engage in behaviours that increase their risk for infection, including unprotected sex, sex in exchange for a commodity and sharing equipment for drug use such as needles (Wainberg & Dixon, 2017: 652). Individuals with both mental illness and HIV might be a direct result of psychiatric symptoms such as hyper sexuality during manic episodes (Hobkirk, Towe, Lion & Meade, 2015: 406).

Co-occurring mental illness and HIV can have several negative consequences such as non-adherence to HIV medication, which will lead to a worsened immune response, increased HIV replication and development of drug resistant viral mutations. In many cases MHCUs living with HIV and AIDS are sexually active and engage in unsafe sexual or drug injection practices. This increase the risk of transmitting HIV, which occurs due to impaired judgement, deficits in volition and impulsivity (Seeman, 2015: 966). Major depressive disorders and substance use disorders have been found to be highly predictive of suicidal ideation in MHCUs living with HIV and AIDS (Badiee *et al*. 2012: 993). HIV infection can result in neuropsychological impairment in approximately 50% of MHCUs. This can affect MHCUs' thought processes and judgement ability (Moore & Posada, 2013: n.p).

Caring for MHCUs living with HIV and AIDS poses a burden to psychiatric nurses and may influence the quality of care. It may result in a high staff turnover, absenteeism, reduced morale, hostile work environment and reduced quality of care (d'Ettorre & Pellicani, 2017: 1). Reduced morale may be rooted in the occupational risk of contracting HIV related to psychiatric nurses who often face physical violence from MHCUs. According to a study done in Canada, approximately 20.3% of psychiatric nurses have been assaulted during their last five shifts (Stevenson, Jack, O'Mara & Le Gris, 2015: n.p).

Moore and Posada (2013: n.p) indicated that apart from MHCUs with HIV and AIDS being potentially violent, they have special needs, which include successfully adhering to treatment recommendations, negotiating disclosure of their HIV status and coping with the potential stigma. These special needs pose challenges to those who treat and care for these MHCUs.

1.3 PROBLEM STATEMENT

The researcher's experience of working with MHCUs living with HIV/AIDS in the psychiatric hospital, which forms the context for this study, made her realize the challenges psychiatric nurses face. For example, the researcher experienced the following: a MHCU presented with symptoms of physical illness and the doctor requested a HIV test. Pre-counselling was done as the MHCU was oriented, not psychotic, and able to sign the consent form. Post-counselling was done after discussing the HIV test results with the MHCU who tested HIV positive. The attitudes of the psychiatric nurses changed towards the MHCU. They started to discriminate against him, treated him differently by labelling him. There seemed to be a sense of anticipation in the unit and caring for a HIV positive MHCU was viewed as a challenge. The reactions of the psychiatric nurses seemed to originate from a fear of contracting HIV/AIDS from MHCUs.

Psychiatric nurses' fear of the population they are serving may affect the quality of care they deliver and lead to increased absenteeism, stress, lower performance and resignations (d'Ettorre & Pellicani, 2017: 337). Fear can trigger a range of physical and emotional outcomes for example anger, shock, depression, anxiety and sleep disruption (d'Ettorre & Pellicani, 2017: 337). Psychiatric nurses' fears and subsequent negative attitudes prevail because of the stigma attached to HIV/AIDS. Stigmatizing ideas may limit psychiatric nurses' ability to respond to HIV prevention needs in psychiatric hospitals. Furthermore, negativity of psychiatric nurses may influence the quality of care rendered (Bimenyimana, Poggenpoel, Myburg & Van Niekerk, 2009: 1).

Challenges psychiatric nurses face include exposure to blood or serum, either from handling injecting equipment, accidental exposure or exposure during assault and violence from MHCUs. The researcher has been a victim of assault herself and witnessed violence towards co-workers caused by MHCUs. Psychiatric nurses may experience fear as a result of lack of knowledge and skills on how to manage HIV/AIDS cases and, consequently, need training that

will highlight awareness of the social, cultural, religious, and spiritual needs of MHCUs living with HIV/AIDS. The researcher attended training regarding this matter, but felt that it was insufficient. Additionally, not all nurses working in the psychiatric hospital were able to attend the session.

Nursing management in psychiatric hospitals face multifaceted challenges posed by MHCUs living with HIV and AIDS. Challenges include factors such as stigma and discrimination against these MHCUs, nurses' fear of aggression and lack of adequate time and resources to meet MHCUs' needs (Giandinoto & Edward, 2014: 728). Another management challenge is providing care to MHCUs living with HIV and AIDS who are suicidal and have self-harming behaviours, aggression and confusion. These MHCUs can evoke a sense of caution in psychiatric nurses due to the real or perceived threat of their own safety (Giandinoto & Edward, 2014: 729). Another challenge that nursing management is facing, is high bed occupancy rates and patient turnover (Sobekwa & Arunachallam, 2015: 1).

The aim of this research was to develop guidelines for nursing management based on the experiences of psychiatric nurses providing care to MHCUs living with HIV and AIDS in a psychiatric hospital in the Gauteng province of South Africa.

1.4 RESEARCH QUESTION

The research questions to be answered were:

- What are psychiatric nurses' experiences of providing care to MHCUs living with HIV and AIDS in a public psychiatric hospital in Gauteng? (phase 1)
- What guidelines can be developed to ensure effective care of MHCUs living with HIV and AIDS in a public psychiatric hospital in Gauteng? (phase 2)

1.5 OBJECTIVES OF THE STUDY

The objectives of this research were:

- To explore and describe psychiatric nurses' experiences of providing care to MHCUs living with HIV and AIDS in a public psychiatric hospital in Gauteng (phase 1).

- To develop guidelines for nursing management based on psychiatric nurses' experiences to ensure effective care to MHCUs living with HIV and AIDS (phase 2).

1.6 SIGNIFICANCE OF THE STUDY

The study uncovered some perceptions, behaviour and attitudes among psychiatric nurses that might influence the quality of care to MHCUs living with HIV and AIDS. The findings were used to develop guidelines for nursing management based on psychiatric nurses' experiences to ensure effective care to MHCUs living with HIV and AIDS. Based on the guidelines training can be implemented to empower psychiatric nurses with skills and knowledge to care for MHCUs living with HIV/AIDS. The guidelines may also serve as a basis to formulate policies to ensure protection of nurses and ethical and equal treatment of MHCUs living with HIV and AIDS. The study might help to reduce the stigma, discrimination and nurses' problematic attitudes towards MHCUs living with HIV and AIDS.

1.7 CLARIFICATION OF CONCEPTS

The main concepts applicable to the study are defined in this section.

1.7.1 AIDS

Acquired immune deficiency syndrome (AIDS) is a potentially fatal condition that develops in the most advanced stage of HIV (World Health Organization [WHO], 2013: n.p). AIDS in this study refers to MHCUs who are diagnosed with AIDS admitted in a specific psychiatric hospital.

1.7.2 Experience

Experience is the practical contact with observation of facts or events (Stevenson & Waite, 2011: 501). In this study experience refers to psychiatric nurses' practical contact with the event of providing care to MHCUs living with HIV/AIDS in a public psychiatric hospital.

1.7.3 Guidelines

Guidelines are recommendations to healthcare users when specific standards do not apply. Guidelines are designed to streamline certain processes according to what the best practices

are. They are more general, provide flexibility and should be open to interpretation and not followed to the letter (Spoden, 2018: n.p). In this study the guidelines will serve as recommendations for nursing management to ensure effective care to MHCUs living with HIV and AIDS

1.7.4 HIV

Human immunodeficiency virus (HIV) is a virus that attacks the immune system and damages the body's ability to fight infections (WHO, 2013: n.p). HIV in this study refers to MHCUs in specific public psychiatric hospitals that are diagnosed with HIV.

1.7.5 Mental health care user

A mental health care user (MHCU) is a person receiving care, treatment and rehabilitation services or using a health service at a health establishment aimed at enhancing his/her mental health status (Mental Health Care Act no 17 of 2002). MHCUs in this study refers to MHCUs admitted in a specific public psychiatric hospital for the management of a mental illness.

1.7.6. Psychiatric hospital

According to the Mental Health Care Act (no 17 of 2002) a psychiatric hospital means a health establishment that provides care, treatment and rehabilitation services only for users with mental illness. In this study 'psychiatric hospital' refers to a specific public psychiatric hospital in Gauteng, one of the nine provinces of South Africa.

1.7.7. Psychiatric nurse

A psychiatric nurse is a registered professional nurse who has been trained to provide prescribed mental health care, treatment and rehabilitation services (Mental Health Care Act no 17 of 2002). In this study a psychiatric nurse refers to a nurse registered with the South African Nursing Council working in a specific public psychiatric hospital.

1.7.8. Psychiatric nursing

Psychiatric nursing is the practice of assessing mental health needs, developing a nursing diagnosis and implementing a plan of care for MHCUs and their families (American Psychiatric Nurses Association, 2018: n.p). In this study psychiatric nursing refers to the practice of assessing mental health needs, developing a nursing diagnosis and implementing a plan of

care for MHCUs living with HIV and AIDS in a specific public psychiatric hospital.

1.8 PARADIGMATIC PERSPECTIVE

The research was conducted within a constructivist paradigm. In the *constructivist paradigm* reality is seen as a construction of the research participants; reality exists within a context; and many constructions are possible. This paradigm reflects the concept of relativism, which is based on the assumption that multiple interpretations of reality exist in people's minds (Polit & Beck, 2012: 12). In this study the experiences of psychiatric nurses while taking care of MHCUs living with HIV/AIDS were explored as these experiences evolved during in-depth interactions with the researcher.

The constructivist paradigmatic perspective guiding the research is further explained in terms of ontological, epistemological and methodological assumptions.

1.8.1 Ontological assumptions

Within the ontological assumptions underlying a constructivist paradigm reality is seen as multiple and subjective and mentally constructed by individuals (Polit & Beck, 2012: 13). Applied to this study the reality of taking care of MHCUs living with HIV/AIDS within the context of the psychiatric hospital is seen as a subjective experience..

1.8.2 Epistemological assumptions

In line with the epistemological assumptions of a constructivist paradigm, the findings of this research are the product of the researcher's interaction with the participants (Polit & Beck, 2012: 13). Psychiatric nurses' experiences of taking care of MHCUs living with HIV/AIDS are crucial to understanding this phenomenon in its entirety and in depth.

1.8.3 Methodological assumptions

Within the methodological assumptions of a constructivist paradigm, the researcher believes the best way to obtain evidence is to be part of a flexible, emergent and inductive process that seeks an in-depth understanding of the phenomenon as grounded in the participants' experience within their specific context (Polit & Beck, 2012: 14-15). The findings of this study in a narrative format are the result of a qualitative analysis of the in-depth knowledge of

psychiatric nurses' experiences of taking care of MHCUs living with HIV/AIDS.

1.9 RESEACH DESIGN AND METHOD

In this section the research design and method followed in the two study phases were briefly discussed. A detailed discussion follows in Chapter 2.

Phase 1

1.9.1 Research design

Research design refers to the plan for obtaining answers to the research questions and for addressing the research challenges (Polit & Beck, 2017: 743). A qualitative, explorative, descriptive and contextual research design was followed.

1.9.1.1 Qualitative design

Polit and Beck (2017: 741) define qualitative research as the investigation of phenomena in an in-depth and holistic way through the collection of rich narrative materials using a flexible research design. The researcher used a qualitative research design in the study as the focus was on understanding the experiences of psychiatric nurses providing care to MHCUs who are living with HIV and AIDS in a psychiatric hospital.

1.9.1.2 Exploratory design

The aim of an exploratory study was to detect the unexpected in the data, gather new data and increase the knowledge of the field of study (Burns & Grove, 2009: 359). An exploratory design was used in this study to gain insight in and gain an understanding of the phenomenon of psychiatric nurses' experiences of providing care to MHCUs living with HIV and AIDS.

1.9.1.3 Descriptive design

A descriptive study is used for the purpose of identifying problems with current practice or determining what others are doing in similar situations (Burns & Grove, 2009: 237). The purpose of descriptive studies is to observe, describe and document aspects of a situation as it naturally occurs (Polit & Beck, 2017: 206). In this study the phenomenon described was psychiatric nurses' experiences of working with MHCUs living with HIV and AIDS.

1.9.1.4 Contextual design

In contextual research the researcher aims at understanding factors that may influence the outcomes of the study in a specific social and environmental setting (Burns & Grove, 2009: 178). The study was conducted among psychiatric nurses working with MHCUs living with HIV and AIDS in a specific context, namely a public psychiatric hospital in Gauteng.

1.9.2 Research method

The research method is outlined in terms of the research setting, role of the researcher, population and sampling, selection of participants, data collection and data analysis. The detailed discussion follows in Chapter 2.

1.9.2.1 Research setting

According to LoBiondo Wood and Haber (2010: 91) the setting may describe two settings: the setting in which the recruitment of participants took place and the setting where data collection took place. Research setting is defined by Polit and Beck (2017: 744) as the physical location and conditions in which data collection takes place. This study was conducted in a specific public psychiatric hospital in Gauteng, one of the nine provinces of South Africa. The hospital is situated in an urban area. At the time of the study, the hospital had 760 beds. The hospital consisted of nine admission units including one acute admission unit for forensic MHCUs, nine chronic units including three chronic forensic units, two units for children and adolescents and an observation unit. MHCUs with different types of mental illnesses are being admitted in the hospital, and the duration of stay in acute admission units ranges from a month to three months depending on the MHCUs' progress.

Although MHCUs are sometimes aggressive, there are no security officers based in the wards. Staff shortages also sometimes play a role, and there are not always enough male nurses on duty to assist when MHCUs present with aggressive behaviour. Staff members are sometimes absent, and it might take time to replace a staff member who resigned, leading to wards sometimes being understaffed.

1.9.2.2 Role of the researcher

The researcher used bracketing which entails putting her own ideas and past experiences regarding the phenomenon under study aside and concentrated on the participants'

experiences (Brink, 2009: 113). The role of the researcher will be further explained in Chapter 2.

1.9.2.3 Selection of participants

Polit and Beck (2017: 739) define population as the entire set of individuals having some common characteristics. The population in the study were all psychiatric nurses who have worked with MHCUs living with HIV and AIDS in a public psychiatric hospital. Participants were selected based on purposive sampling which is defined as a method in which the researcher selects participants based on personal judgment about which ones will provide the most required information (Polit & Beck, 2017: 741).

1.9.2.4 Data collection

Data collection is the process of gathering information to address a research problem (Polit & Beck, 2017: 725). The data-collection method used in this study was unstructured interviews (Burns & Grove, 2011: 402, 510).

1.9.2.5 Data analysis

According to Polit and Beck (2017: 725) data analysis is a systematic organization and synthesis of research data. Qualitative content analysis was done to analyze the transcribed data according to the steps as described by Tesch in Creswell (2009: 185).

<u>Phase 2</u>

1.9.3 Guideline development

The draft guidelines were developed by the researcher in accordance with and guided by the following: discussion of findings and literature review (Chapter 3) and guiding attributes in the guideline-development process as discussed in this section.

1.9.3.1 Guiding attributes in the guideline-development process

The attributes that guided the researcher throughout the development process were derived and adapted from the AGREE II instrument (Brouwers, Kho, Browman, Cluzeau, Feder, Fervers, Hanna & Makarski on behalf of the AGREE Next Steps Consortium, 2010) and the Institute of Medicine (2010: 214–228).

The guidelines were developed using a representative process that includes participation by representatives of the target group. The guidelines were based on phase 1 of this study, which represents the psychiatric nurses' experiences. The process of developing guidelines, the evidence used, the assumptions made, and participants involved were accurately documented and described in Chapter 4.

1.9.3.2 Validation of guidelines

The guidelines were validated by a Delphi panel of experts to ensure validity, reliability, applicability, clarity and flexibility. The Delphi technique is a systematic procedure used to achieve consensus among a panel of experts (Keeney, 2010: 228). In this study the researcher selected participants from experts in the field of HIV/AIDS, psychiatric nursing and nursing management. Participants were requested to rate each guideline and its actions regarding the criteria of reliability, validity, applicability, clarity and flexibility. The response choices were based on a four-point Likert-type scale to measure levels of agreement (Jones & Rattray, 2010: 376). Responses from participants were screened, analysed and collated in a table format according to the levels of agreement using the Likert scale. See 2.4.2 for the detailed description of the Delphi method.

1.10 STRATEGIES TO ENSURE TRUSTWORTHINESS

Lincoln and Guba's model described by Polit and Beck (2017: 559) was used to ensure trustworthiness of the findings. According to this model the following criteria were followed: credibility, transferability, dependability, conformability and authenticity. See section 2.5 in Chapter 2 for a detailed discussion of trustworthiness.

1.11 ETHICAL CONSIDERATIONS

The research must be ethical, which means that the participants' rights and the rights of others in the setting are protected (Burns & Grove, 2005: 83). The study received ethical approval from the Research Ethics Committee of the Faculty of Health Sciences, University of Pretoria (Annexure 3). Written consent was obtained from the Chief Executive Officer of the psychiatric hospital where the study will be conducted (Annexure 4). In this research the principles of the Belmont report (Polit & Beck, 2017: 139) were applied: beneficence, respect for human dignity and justice. See section 2.6 in Chapter 2 for a detailed discussion of ethical considerations.

1.12 LAYOUT OF THE RESEARCH

Chapter 1: Overview of the study
Chapter 2: Research design and methodology
Chapter 3: Discussion of findings and a literature control
Chapter 4: Development and refinement of guidelines
Chapter 5: Discussion of limitations, conclusions and recommendations.

1.13 DISSEMENATION OF FINDINGS

The researcher will disseminate the findings by publishing an article. The findings will also be presented at a national conference.

1.14 CONCLUSION

This chapter includes the background and rationale upon which this research was based, the problem statement, research design and methodology, data collection and analysis, measures to ensure trustworthiness and ethical considerations that will guide the researcher. Chapter 2 provides a detailed description of the research design and method.

CHAPTER 2: RESEARCH DESIGN AND METHODOLOGY

2.1 INTRODUCTION

In Chapter 1 the research background and problem statement were discussed as well as an overview of the methodology. In Chapter 2 the two study phases are discussed according to the objectives, research design and method with the research setting, population, sampling and recruitment of participants as well as data collection and data analysis. Measures to ensure trustworthiness and ethical considerations are applied to the study.

2.2 OBJECTIVES OF THE STUDY

The objectives of this research were:

- To explore and describe psychiatric nurses' experiences of providing care to MHCUs living with HIV and AIDS in a public psychiatric hospital.
- To develop guidelines for management based on psychiatric nurses' experiences to ensure effective care to MHCUs living with HIV and AIDS.

2.3 RESEARCH DESIGN AND METHOD: PHASE 1

In this section the research design and method followed in phase 1 are discussed.

2.3.1 Research design

Research design refers to the plan for obtaining answers to the research questions and for addressing the research challenges (Polit & Beck, 2017: 743). According to de Vos, Strydom, Fouche and Delport (2011: 109) research design means the researcher's plan to answer the research question. The researcher's rationale for the choice of a qualitative, descriptive, exploratory and contextual design will subsequently be discussed.

2.3.1.1 Qualitative design

Burns and Grove (2011: 739) define qualitative research as the investigation of phenomena in

an in-depth and holistic way through the collection of rich narrative materials using a flexible research design. The researcher used a qualitative research design in phase 1 as the focus was on understanding the experiences of psychiatric nurses providing care to MHCUs living with HIV and AIDS in a psychiatric hospital.

According to Mouton and Prozesky (2011: 270) a qualitative design is defined as describing and understanding human behaviour and the emphasis is on studying human action in its natural setting through the eyes of the actors themselves. It is a means for exploring and understanding the meaning individuals or groups ascribe to a social or human problem. It involves emerging questions and procedures, collecting data in the participants' setting, analysing the data inductively, building from specifics to general themes and making interpretations of the meaning of the data. The final report has a flexible writing structure (Creswell, 2009: 232).

In this study data collection was done through interviews with nurses who had experiences of taking care of MHCUs living with HIV and AIDS. Qualitative methodology was more appropriate to this research question because when seeking reasons for behaviour one moves into areas of human purpose and volition. The researcher physically went to the people and the site to record in the natural setting; she was interested in understanding and interpreting the meanings and the intentions underlying psychiatric nurses' everyday experiences.

2.3.1.2 Exploratory design

The aim of an exploratory study is to detect the unexpected in the data, gather new data and increase the knowledge of the field of study (Burns & Grove, 2009: 359). It involves a researcher examining a new interest or when the subject of study itself is relatively new, it is done to satisfy the researcher's curiosity and desire for better understanding. It is also used to test the feasibility of undertaking a more extensive study, to develop methods to be employed in any subsequent study, explicate the central concepts to determine priorities for future research or to develop new hypotheses about an existing phenomenon (Mouton & Prozesky, 2011: 80).

An exploratory design was used in this study to gain insight in and gain an understanding of the phenomenon of psychiatric nurses' experiences of providing care to MHCUs living with HIV and AIDS.

2.3.1.3 Descriptive design

A descriptive design is used for the purpose of identifying problems with current practice or determining what others are doing in similar situations (Burns & Grove, 2009: 237). The purpose of descriptive studies is to observe, describe and document aspects of a situation as it naturally occurs (Polit & Beck, 2017: 206). Descriptive studies refer to when a researcher observes and then describes what was observed (Mouton & Prozesky, 2011: 80).

In this study the phenomenon described was psychiatric nurses' experiences of working with MHCUs living with HIV and AIDS. The researcher described the findings using the participants' direct quotations as obtained during the interviews.

2.3.1.4 Contextual design

In contextual research the researcher aims at understanding factors that may influence the outcomes of the study in a specific social and environmental setting (Burns & Grove, 2009: 178).

The study was conducted among psychiatric nurses working with MHCUs living with HIV and AIDS in a specific context, i.e., a public psychiatric hospital in Gauteng, South Africa (see 1.8.2.1).

2.3.2 Research method

The research method for phase 1 is discussed in terms of the research setting, role of the researcher, population and sampling, selection of participants, data collection and data analysis.

2.3.2.1 Research setting

See point 1.8.2.1 for discussion of the research setting.

2.3.2.2 Role of the researcher

Under the role of the researcher, bracketing, intuiting and interview skills are discussed.

The researcher used bracketing, which entails putting her own ideas and past experiences

regarding the phenomenon under study aside and concentrate on the participants' experiences (Brink, 2009: 113). Here the researcher listened carefully to cues in order to avoid interrupting before the participants had completed answering a question. The researcher also avoided using her past experiences as a psychiatric nurse to make own judgments.

Polit and Beck (2017: 732) describe intuiting as occurring when the researcher remains open to the meaning attributed to the phenomenon by those who experienced it. It entails thinking through the data so that a true, comprehensive and accurate interpretation of what is meant is achieved. In intuiting the researcher became absorbed in the phenomenon, looking at it afresh, without layering it with what she bracketed out from her previous experience as a psychiatric nurse. After the interview had begun, the role of the researcher was to encourage participants to continue talking using both verbal and non-verbal communication skills. Nonverbal communication can be critical in conveying concern and interest. Facial expressions, for example, help to set the tone for the interview. Good data collectors need to pay attention to non-verbal behaviour that indicates both self-awareness and an awareness of a participant's non-verbal behaviour (Polit & Beck, 2017: 516).

The researcher started by building rapport with participants and progressed to the sensitive questions after a relationship of trust had been built. The most critical skill for an in-depth interview is being a good listener. It is important not to interrupt respondents, to lead them, to offer advice or opinions or to counsel them. The interviewer's job is to listen intently to the participants' stories (Polit & Beck, 2017: 516). Here the researcher ensured that she listened carefully to cues and every detail coming her way and she avoided interrupting before the participants had finished answering her questions.

Asking questions and noting an answer is a natural process, but the way we ask questions subtly biases the answers we get (Mouton & Prozesky, 2011: 289). Probing encourages participants to give more information using open-ended questions (Polit & Beck 2017: 280). Probing are also a useful way to gather information as it helps to get more in-depth answers, but one need to learn the skill of being a good listener (Mouton & Prozesky, 2011: 289). According to Polit and Beck (2017: 280), in order to elicit more useful information than participants volunteered during their initial reply, one needs to probe. Probing can take many forms, such as repeating the original question or pausing, which will communicate to participants that they should continue. Polit and Beck (2017: 516) present that qualitative

interviewers need to be good listeners and need to hear all that is being said. In this study the researcher made sure that she listened carefully with understanding in order to interpret the meanings and the intentions that influenced participants' actions.

2.3.2.3 Selection of participants

Polit and Beck (2017: 737) define population as the entire set of individuals having some common characteristics. The population of the study was all psychiatric nurses who have worked with MHCUs living with HIV and AIDS in a public psychiatric hospital. The participants must have had at least six months and more experience working with MHCUs living with HIV and AIDS and must have been able to speak English.

Participants were selected based on purposive sampling, which is defined as a method in which the researcher selects participants based on personal judgment about which ones will provide the most required information (Polit & Beck, 2017: 741). Participants were selected and sampling and data collection occurred until data saturation occurred. Data saturation refers to a point when information being shared becomes repetitive. It means the ideas shared by participants have been shared before by other participants and inclusion of additional participants does not result in new ideas (LoBiondo-Wood & Haber, 2010: 91). After eight participants were interviewed themes started to repeat themselves during the interviews and two more participants were selected and interviewed to ensure saturation.

Sampling was done by purposeful selection; that is an invitation was made to all candidates who met the inclusion criteria. The researcher introduced the study to potential participants during ward meetings and left leaflets with her contact details for those who were interested to contact her to participate in the study. An appointment was scheduled with potential interested participants to ensure they met the inclusion criteria and signed informed consent. The following inclusion criteria were followed:

Inclusion criteria

- Sampling was limited to psychiatric nurses who were working with or who previously worked with MHCUs living with HIV and AIDS in the specific hospital.
- Participants had to have at least six months' experience of caring for MHCUs living with HIV and AIDS to have enough experience of the phenomenon under study.
- Participants were selected from day and night shifts.

- Participants were engaged in the study on a voluntary basis after informed consent had been obtained.

2.3.2.4 Data collection

Data collection is the process of gathering information to address a research problem (Polit & Beck, 2017: 725). The data collection method used in this phase was unstructured interviews, which involved verbal communication between the researcher and the participant. The interviews were supplemented by field notes.

a) Unstructured interviews

Unstructured interviews are the most appropriate and informative way of gaining the participants' experiences in research (Burns & Grove, 2011: 402, 510). Polit and Beck (2017: 510) indicated that the researcher should in advance prepare a written interview guide (Annexure 2) and encourage participants to talk freely about their experiences. According to the interview guide, the researcher asked the following questions during the unstructured interviews:

What are your experiences of providing care to MHCUs living with HIV and AIDS in a psychiatric hospital in Gauteng?

Being potentially exposed to HIV while working with MHCUs in a psychiatric hospital, how does it affect you as a person and your performance at work?

The information leaflet was discussed with participants and they signed informed consent before conducting the interview. Environmental distractions are common pitfalls in recording interviews. A quiet setting without disruptions is ideal, but is not always possible (Polit & Beck, 2017: 508).

For this study the venue for the interview was carefully chosen for privacy and for a relaxed atmosphere free from interruptions. The researcher tried to avoid any environmental distractions during the interviews by arranging a private office where a note was placed on the door indicating that interviews were in progress. The researcher ensured that the normal workflow and service delivery were not disrupted by the interviews. Interviews were done in different wards. The participant was set at ease before the exploratory questions were asked. An audio-recorder was used to ensure completeness of verbal interaction. Very few field notes

were made during the interview as it was found during the first interviews that attempts to write during the interviews interfered with active listening. Notes were made immediately after each interview using a research diary. The interview concluded when the researcher found that the participant had nothing more to say. Most interviews lasted between 45 and 55 minutes. Demographic data was recorded on each participant, including age and length of service.

b) Field notes

According to Polit and Beck (2017: 521) field notes represent the researcher's efforts to record information and to synthesize and understand the data. The researcher used observational, methodological, theoretical and reflective notes.

- **Observational notes**

Observational notes are objective descriptions of observed events and conversations, information about actions, dialogues and context; and are to be recorded as completely and objectively as possible (Polit & Beck, 2017: 521). For this phase the researcher observed the participants during the interviews; their feelings, actions and the way they talked when asked questions. The researcher ensured that she gathered first-hand information as it occurred and focused on non-verbal behaviour, such as changing positions more often and scratching fingers. The researcher took notes to help with the reformulation of questions and probes and to record non-verbal communication. The researcher is a psychiatric nurse and has conducted many therapeutic interviews.

- **Theoretical notes**

Theoretical notes document the researcher's thoughts about how to make sense of what is happening. These notes serve as a starting point for subsequent analysis (Polit & Beck, 2017: 522). For phase 1 the researcher wanted to understand the nurses' experiences of providing care to MHCUs living with HIV and AIDS. The theoretical notes helped the researcher to understand participants' underlying feelings.

- **Methodological notes**

Methodological notes refer to reflections about methodological strategies. It can also provide instructions or reminders about how subsequent interviews will be made (Polit & Beck, 2017: 522). For this study the researcher reflected in her field notes on methodological issues, such as 'ask more open-ended questions' and 'rephrase questions to obtain better information from

participants, for example, ask participants to elaborate on or describe'.

- **Personal notes**

Personal notes are comments about the researcher's own feelings in the field. Field experiences give rise to personal emotions and challenge the researcher's assumptions. It is essential to reflect on such feelings, because there is no other way to know whether the feelings are influencing what is being observed or what is being done in the participant's role (Polit & Beck, 2017: 522). With reflective notes the researcher documented her personal experiences, reflections and progress. She explored her own experiences and feelings and reflected on the progress that is needed to obtain the data. The personal notes also helped with bracketing as the researcher noted her own biases.

2.3.2.5 Data analysis

According to Polit and Beck (2017: 725) data analysis is a systematic organization and synthesis of research data. The audio recorded interviews were transcribed verbatim (example in Annexure 5). After transcription, data analysis was done by first reading through the material a few times to become familiar with the data. Qualitative content analysis was done to analyse the transcribed data according to the steps as described by Tesch in Creswell (2009: 185):

Step 1: Organise and prepare the data for analysis. It involved transcribing interviews and typing the field notes.

Step 2: Step 2 involved reading through the data to obtain a general sense of the information and to reflect on its overall meaning, checking for general ideas, tone of the ideas, impression of the overall depth and credibility of information. The researcher read through the material a few times in order to become familiar with the data.

Step 3: Begin detailed analysis with a coding process. The researcher segmented sentences or paragraphs and labelled those categories with a term based in the actual language of the participant. Similar ideas were clustered and similar topics allocated with codes. The researcher listed the themes and arranged themes into categories after naming and coding each theme. The researcher compared the main themes, unique themes and leftover themes, and noted interrelationships between the themes. In this study common themes were identified and interpreted.

Step 4: The researcher described the research setting, categories and themes as derived from the data. In this study the identified themes were discussed relating to the main questions that had been asked.

Step 5: Step 5 involved the researcher narrating the themes to convey descriptive information of the findings. In this study a table was used to convey descriptive information of the research findings.

Step 6: This step involves interpreting the data and asking questions. This involved the researcher's personal interpretations, couched in the understanding that she brings to the study from her own culture, history and experiences. Coding refers to process of transforming raw data for data processing and analysis, for instance attaching numbers to categories, identifying and indexing recurring word, themes or concepts within the data (Polit & Beck, 2017: 722).

The researcher used an independent coder (Annexure 6) to analyse the data after which the coder and researcher met to agree on the themes and categories. The researcher conducted a literature review and compared the themes and categories with similar literature findings.

2.4 GUIDELINE DEVELOPMENT PROCESS: PHASE 2

The guideline development process, followed by the validation of the guidelines according to a Delphi method will be discussed in this section.

2.4.1 Development of guidelines

The draft guidelines were developed by the researcher in accordance with and guided by the following: discussion of findings and literature review (Chapter 3) and guiding attributes in the guideline development process as discussed in this section.

2.4.1.1 Guiding attributes in the guideline development process

The attributes that guided the researcher throughout the development process were derived and adapted from the AGREE II instrument (Brouwers, Kho, Browman, Cluzeau, Feder, Fervers, Hanna & Makarski on behalf of the AGREE Next Steps Consortium, 2010) and the Institute of Medicine (2010: 214–228).

Scope and purpose is concerned with the overall aim of the guidelines, the research questions, and the target population. Stakeholder involvement focuses on the extent to which the guideline was developed by the appropriate stakeholders and represents the views of its intended users. Rigour relates to the process used to gather and synthesize the evidence, the methods to formulate the recommendations, and to update them. Clarity deals with the language, structure, and format of the guideline. Applicability pertains to the likely barriers and facilitators to implementation and resources to implement the guidelines (Brouwers *et al.*, 2010: 10). Flexibility means that changes can be made to the guidelines as new arguments emerge (Gnatzy, Warth, Von der Gracht & Darkow, 2011: 1686).

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a) Rigour: validity and reliability

As recommended by Brouwers *et al.* (2010: 22), the following criteria were used to ensure rigour of the guidelines: Systematic methods were used to search for the evidence and the evidence is clearly described in Chapter 3. The strengths and limitations of the study is described in Chapter 5. The link between the guidelines and the supporting evidence is indicated in Table 4.1. The guidelines were externally reviewed by experts prior to its publication. The Delphi panel were asked to rate the guidelines in terms of validity: Guideline will facilitate effective care to MHCUs living with HIV and AIDS; and reliability: Given the same circumstances psychiatric nurses would interpret and apply the guideline similarly. A procedure for updating the guideline is provided in Chapter 4.

b) Clarity

As recommended by Brouwers *et al.* (2010: 31), the following criteria were used to ensure clarity of the guidelines: The guidelines are specific and unambiguous, the different options for management of the MHCUs living with HIV and AIDS are clearly presented, and the recommendations are presented in Chapter 5. The Delphi panel were asked to determine the extent to which the guidelines are precise, unambigious, user-friendly and logic.

c) Flexibility

The Delphi panel was asked to comment on the flexibility of the guidelines (Institute of Medicine, 2011: 214–228) to ensure that the guidelines are flexible enough to be adapted to different practice settings: They rated the guidelines according to the following criterion: Guideline will empower psychiatric nurses caring for MHCUs living with HIV and AIDS to implement changes as applicable and re-evaluate their practice.

d) Applicability

As recommended by Brouwers *et al*. (2010: 35), the following criteria were used to ensure applicability of the guidelines: The guideline describes facilitators and barriers to its application and actions on how the guidelines can be implemented (see section 4.3.1 – 4.3.7). The potential resources of applying the guidelines are set out at the end of this chapter. The Delphi panel rated the guidelines according to the following criterion for applicability: Target population is clearly stated: Psychiatric nurses caring for MHCUs living with HIV and AIDS.

e) Stakeholder involvement

The Delphi panel included representatives of the group targeted for the guidelines, namely psychiatric nurses, health care professionals and other experts in the field of study. The guidelines were based on phase 1 of this study which represents the psychiatric nurses' experiences. Review of the guidelines was recommended after development. The process of developing guidelines, the evidence used, assumptions made and participants involved were accurately documented and described.

f) Scope and purpose

The overall objectives of the guideline are specifically described. The research questions covered by the guideline are specifically described in Chapter 1. The population to whom the guideline is meant to apply is described throughout the study (Brouwers *et al*., 2010: 14).

2.4.2 Validation of guidelines

The Delphi technique was used in this study to validate the guidelines. This technique is a systematic procedure used to achieve consensus among a panel of experts Expert opinions are requested by using a series of questionnaires on a specific subject. The process stops when consensus is reached that the research question has been answered (Keeney, 2010: 228). In this study input was obtained from experts in the field of HIV/AIDS, psychiatric nursing and nursing management.

2.4.2.1 Selection of participants

Purposive sampling is used in a Delphi study. The participants are selected for a purpose, i.e., to apply their knowledge to a certain problem based on the criteria (Keeney, Hasson & McKenna, 2011: 228). The researcher recruits individuals who are perceived to have

expertise in and knowledge of the subject under investigation (Keeney, Hasson & McKenna, 2011: 7; Keeney, 2010: 229).

Potential participants were invited to participate of which 15 indicated their willingness to participate in the validation of the guidelines. Participants were selected in accordance with the following inclusion criteria:

- Participants interested and knowledgeable about the topic; and
- Participants involved in the identified fields (psychiatric nursing and management, and HIV and AIDS), either in conducting research, teaching or being actively employed in the field at the time of the study.

2.4.2.2 Delphi technique

The Delphi technique involves questionnaires being sent out till consensus is reached. The guidelines sent to the participants to rate the guidelines and recommend changes (Gerrish & Lacey 2013: 230). The technique will be discussed based on the data-collection method and instrument and data analysis.

a) Data-collection method and instrument

During data collection, questionnaires are filled in and returned to the researcher, who analyses the responses (Gnatzy, Warth, Von der Gracht & Darkow, 2011: 1526). In this study selected participants were contacted personally by the researcher or by e-mail through a cover letter explaining the objectives of the Delphi and the conditions of participation. Participants were given a deadline to indicate their willingness to respond; where after the instrument to validate the guidelines, a cover letter including instructions, deadlines, study objectives, summary of the findings and informed consent leaflets were e-mailed, or provided personally to potential participants. The purpose was explained to the participants to encourage the participant to take part in the study (Gnatzy, Warth, Von der Gracht & Darkow, 2011: 1683). Participants were requested to rate each guideline and its actions regarding the criteria of reliability, validity, applicability, clarity and flexibility. The response choices were based on a four-point Likert-type scale to measure levels of agreement (Jones & Rattray, 2010: 376).

b) Data analysis

Data analysis was done in accordance with the participants' rating of the guidelines. All entries were kept anonymous. The number of responses were recorded in a table format according to the levels of agreement using the Likert scale. A quality score was calculated for each of the five criteria. Scores were calculated by summing up all the scores of the individual items for a criterion and by scaling the total as a percentage of the maximum possible score for that criterion (Brouwers et al., 2010: 12).

2.5 STRATEGIES TO ENSURE TRUSTWORTHINESS

This section indicates how trustworthiness was ensured for Phase 1 of the study. Lincoln and Guba's model described by Polit and Beck (2017: 559) was used to ensure trustworthiness of the findings. According to this model the following criteria were followed: credibility, transferability, dependability, conformability and authenticity.

2.5.1 Credibility

Credibility refers to the truth of the findings as judged by the participants and others within the discipline (LoBiondo, Wood & Haber, 2010: 119). The following subheadings are discussed under credibility: prolonged engagement, reflexivity, triangulation and authority of the researcher.

2.5.1.1 Prolonged engagement

Prolonged engagement refers to investment of enough time during data collection to have an in-depth understanding of the phenomenon under study (Polit & Beck, 2017: 740). It includes staying in the field until data saturation occurs. Credibility was ensured through prolonged engagement in the study field with the participants to capture the realities of the study. The interviews lasted between 50 and 60 minutes. The researcher carried on with interviews until saturation was reached when no new themes emerged.

2.5.1.2 Reflexivity

Reflexivity is a process of reflecting critically on the self and of analysing and making notes of personal values that could affect data collection and interpretation (Polit & Beck, 2017: 561). The researcher tried to avoid using or applying her personal experiences during the interviews. As a former employee of the institution which formed the study context, she needed to stay

aware of her own interpretations of the study phenomenon.

2.5.1.3 Triangulation

Mouton and Prozesky (2011: 277) refer to triangulation as the best way to elicit the various and divergent constructions of reality that exist within the context of a study. This is done by collecting information about different events and relationships from different points of view, asking questions, seeking different sources and using different methods

Triangulation of data collection was ensured by capturing field notes during the unstructured interview sessions. The field notes and the audio recordings of all the interview proceedings were given to an independent coder to analyse and allocate themes, categories and sub-categories. The researcher also used triangulation of participants by using psychiatric nurses working different shifts.

2.5.1.4 Authority of the researcher

Authority refers to a person with specialized expertise (Polit & Beck, 2017: 8). The researcher used resources that are valid and reliable to support her findings. The researcher herself is experienced in the field of study.

2.5.2 Transferability

Transferability refers to the potential for extrapolation that is the extent to which findings can be transferred to or have applicability in other settings or groups. It refers to the extent to which findings can be applied in other contexts or with other respondents (Mouton & Prozesky, 2011: 277). The researcher's responsibility is to provide enough descriptive data so that consumers can evaluate the applicability of the data to other contexts (Polit & Beck, 2017: 560). The researcher described the context, design, findings and methods in-depth so that the reader can decide on transferability to another context.

2.5.3 Dependability

Dependability is defined as a criterion for evaluating integrity in qualitative studies, referring to the stability of data over time and over conditions, analogous to reliability in qualitative research (Polit & Beck, 2017: 559). A reliable research method was used to ensure that the results are trustworthy. An independent coder was involved to determine whether the findings

are a true reflection of participants' views. A consensus discussion was held between the researcher and independent coder to ensure consensus in identification of themes. The guidelines were validated using a Delphi method.

2.5.4 Conformability

Conformability refers to the neutrality of the data, potential for congruence between two or more independent people about the data accuracy and relevance or meaning. (Polit & Beck, 2017: 723) According to Mouton and Prozesky (2011: 279) conformability refers to the degree to which the findings are the product of the focus of the inquiry and not of the biases of the researcher. For this study conformability was ensured by sending the copies of the verbatim transcripts, field notes and data analysis protocol to an independent coder for analysis. The guidelines were validated using an independent Delphi panel.

2.5.5 Authenticity

Authenticity refers to the extent to which the researcher fairly and faithfully shows a range of different realities. It emerges in a report when it conveys the feeling tone of the participants' experiences as they are lived-the-mood feelings, language and the context of participants (Polit & Beck, 2017: 560). Authenticity was attained through using participants' direct quotations in the findings to reflect their experiences. Burns and Grove (2011: 541) defined a literature control as a critical summary of theory and empirical sources to generate a picture of what is known and not known about a specific problem. Polit and Beck (2017: 733) indicated that a literature control is done to put a research problem in context. In this study the literature control was conducted after data analysis to place the findings within current related theories and research findings.

2.5.6 Validity and reliability of the guidelines

Consensus was reached on the validity and reliability of the guidelines. To ensure credibility of the Delphi, a clear decision trail is evident in the research report (Keeney, Hasson & McKenna, 2011: 3–5).

2.6 ETHICAL CONSIDERATIONS

The researcher must be ethical, which means that the participants' rights and rights of others in the setting are protected (Burns & Grove, 2005: 83). The study received ethical approval from the Research Ethics Committee of the Faculty of Health Sciences, University of Pretoria (Annexure 3). Written consent was obtained from the Chief Executive Officer of the psychiatric hospital where the study was conducted (Annexure 4). In this research the following principles of the Belmont Report (Polit & Beck, 2017: 139) were applied as are discussed: beneficence, respect for human dignity and justice.

2.6.1 Beneficence

Beneficence refers to taking positive actions to help others while non-maleficence refers to researchers' obligations to avoid, prevent or minimize harm (Potter & Perry, 2009: 314). Non-maleficence in this study meant the researcher obtained approval from the institution (Annexure 4) and obtained written consent from the psychiatric nurses (Annexure 1), as well as permission to use the venue where the interviews were conducted. Written consent was obtained from the Delphi participants (Annexure 8). This study might benefit the institution by exploring the problem. The institution might implement the recommendations as a result of the study, which in turn might reduce absenteeism, unrealistic workload expectations and resignation of personnel.

After obtaining permission from the hospital management the researcher informed all psychiatric nurses in the wards during their monthly climate meetings about the research. The participants were told that no one will have access to the recorded interviews and the participants' names will remain anonymous and ensure participation is voluntary. The researcher informed the participants that no awards will be given for participation in the study and that there will be no penalties if one needs to withdraw from the study.

Written consent was obtained from all the participants. The confidentiality of the participants was protected by not using any names or identifying details on transcribed interviews. Instead interviews were marked with codes. The audio-recoded interviews were destroyed to ensure anonymity.

2.6.2 Respect for human dignity

The right to self-determination means that the participants have the right to decide voluntarily whether to participate in a study without risking any penalty or prejudicial treatment. It also means that participants have the right to ask questions, to refuse to give information or to withdraw from the study. The researcher's responsibility is to make the participants aware of these rights and to respect their choices (Polit & Beck, 2017: 140).

The researcher obtained informed consent by providing participants with information leaflets to be fully aware of what the study entails (Annexure 1). The researcher ensured that the research was not more intrusive than it needed to be. Participants' privacy was maintained throughout the study. According to Burhardt and Nathaniel (2002: 54) confidentiality means that people who have access to the data will sign an agreement to keep personal information identifying participants confidential. People that have access to the documents were the transcriber, the supervisor and the independent coder. The transcriber and coder signed confidentiality agreements. The research report did not include any information or detail by which participants could be identified. Codes were used on the transcripts of interviews and Delphi questionnaires rather than the names of participants (Polit & Beck, 2017: 722). Transcribed and analysed interviews and Delphi questionnaires will be locked in a safe place for 15 years.

2.6.3 Justice

Justice is participants' right to fair treatment (Potter & Perry, 2009: 314). Justice includes the participants' right to privacy. The selection of study participants was based on research requirements and not on the vulnerability of certain people. Participants who terminated participation were not subjected to any penalties or any sort of punishment (Polit & Beck, 2017: 141). The participants were selected according to their experiences related to the research problem and the Delphi participants were selected in the same way.

The researcher did understand and respect different beliefs, habits and lifestyles of the participants. The researcher was not biased and did not use her experiences as a psychiatric nurse to lead participants in giving opinions and answers that she wanted. The inclusion criteria gave potential participants an equal chance to take part in the study. The researcher had no relation to the participants although she previously worked with some of them. She was not part of the hospital management team.

The participants were informed in advance about the possible emotional discomfort that might be experienced during the interviews. Participants who experienced emotional discomfort related to the study, were provided with information on how to get professional help from the employee wellness programme available in the hospital. However, no participants required any professional help from this programme, because all participants were debriefed and provided with coping skills after the interviews due to the sensitivity of this study.

2.7 CONCLUSION

In this chapter the researcher design and research methodology were discussed according to the two phases of the study. The research population, sampling and recruitment of participants were discussed in detail. Data collection and data analysis were also described. The measures to ensure trustworthiness, namely credibility, conformability, transferability, and dependability were dealt with in depth. The ethical considerations were also presented. The findings and literature review are presented in Chapter 3.

CHAPTER 3: DISCUSSION OF FINDINGS AND LITERATURE CONTROL

3.1 INTRODUCTION

This chapter includes the findings of the study and literature control. Data from the interview transcripts were grouped into four main categories: experiences of fear caring for MHCUs living with HIV/AIDS, experiences of aggressive behaviour of MHCUs living with HIV/AIDS, experiences of difficulties in caring for MHCUs living with HIV/AIDS and a need for support in caring for MHCUs living with HIV/AIDS. These were subdivided into subcategories. Each subcategory was discussed by using verbatim quotations in italics. Each subcategory was supported by a literature discussion.

3.2 DEMOGRAPHIC INFORMATION

A total of nine interviews were conducted with registered nurses working in different wards in a psychiatric hospital. Purposive sampling was used to ensure that those participants who had the experiences of providing care to MHCUS living with HIV/AIDS were included. The participants were all registered nurses employed in this psychiatric hospital. The demographic characteristics of the participants are illustrated in table 3.1.

Table 3.1: Demographic profile of participants

CRITERION	CHARACTERISTICS	FREQUENCY
Gender	Female	9
Years of service	3-6 years	9
Designation	Registered nurse with psychiatric nursing science	9
Experience of working with MHCUs with HIV/AIDS	3–5 years	9

The research question was clear and easily understood by the participants and prompted a spontaneous response from the participants. The following central question was asked: *What are your experiences of providing care to MHCUs living with HIV/AIDS in a psychiatric*

hospital? Information related to the research question was obtained in 45 to 60 minutes and saturation of data was reached after nine interviews. Some of the factors were repeated in most of the interviews and no new factors were raised. The researcher made use of communication skills, such as probing, clarification, listening and reflection to obtain enough data.

3.3 PROCESS OF DATA ANALYSIS

The researcher commenced with data analysis independently of the co-coder. Coding was guided by Tesch's open-coding method (Creswell, 2009: 185). The researcher read through the verbatim transcripts and started underlining the words and phrases of the participants' responses to the research question. As the analysis proceeded, categories for the study were identified and subcategories developed within the framework. Both the researcher and co-coder agreed on these categories. Furthermore, new categories were developed, which had not been identified before. The co-coder was given unmarked copies of the transcripts as well as the field notes. Consequently, consensus was reached regarding the findings and the data analysis method. See Annexure 6 for the co-coder certificate.

The central theme identified was that psychiatric nurses are challenged in caring for MHCUs living with HIV/AIDS. A summary of the categories and sub-categories can be found in table 3.2.

Table 3.2: Experiences of nurses working with MHCUs living with HIV/AIDS in a psychiatric hospital

CATEGORIES	**SUB-CATEGORIES**
3.4.1 Experiences of fear caring for MHCUs living with HIV/AIDS	3.4.1.1 Fear of being infected by MHCUs 3.4.1.2 Fear of being attacked by MHCUs
3.4.2 Experiences of aggressive behaviour of MHCUs living with HIV/AIDS	3.4.2.1 Lack of insight into condition by MHCUs 3.4.2.2 Aggressive outbursts of MHCUs place nurses at risk 3.4.2.3 Intention to resign due stress of caring for MCHUs 3.4.2.4 Emotional turmoil in caring for MHCUs living with HIV/AIDS
3.4.3 Experiences of difficulties in caring for MHCUs living with HIV/AIDS	3.4.3.1 Lack of support from management 3.4.3.2 Attitude of personnel towards HIV positive MHCUs 3.4.3.3 Duty to care
3.4.4 A need for support in caring for MHCUs living with HIV/AIDS	3.4.4.1 Recommendations for support of psychiatric nurses • Continuous professional development • Teamwork/support for each other 3.4.4.2 Recommendations for support of MHCUs

3.4 FINDINGS AND LITERATURE CONTROL

Data from the interview transcripts were grouped into four main categories (see Table 3.2): experiences of fear caring for MHCUs living with HIV/AIDS, experiences of aggressive behaviour of MHCUs living with HIV/AIDS, experiences of difficulties in caring for MHCUs living with HIV/AIDS and a need for support in caring for MHCUs living with HIV/AIDS. These were subdivided into subcategories. Each subcategory will be discussed with verbatim quotations in italics. The number of the participant is indicated in brackets after the quotation, for example, Intw 1 (Interview 1). Each subcategory is followed by a literature discussion.

3.4.1 Experiences of fear caring for MHCUs living with HIV/AIDS

Under the first category, ‘experiences of fear caring for MHCUs living with HIV/AIDS’, the following subcategories were identified: fear of being infected by MHCUs and fear of being attacked by MHCUs.

3.4.1.1 Fear of being infected by MHCUs

The participants indicated that they are not able to do their work to the best of their ability, because they are afraid that they might be infected while caring for MHCUs. The participants also indicated that they do not feel free to intervene with these MHCUs, because they think some of the MHCUs have intentions of infecting them. The participants' views were expressed as follows:

"I don't feel free, because I think maybe he (a MHCU) *wants to infect us intentionally." (Intw 2)*

"We nurses are very afraid of being infected. What we do once we know patient so and so has this disease, we try to play safe. You just keep your distance between you and the patient. The thing is, these patients like to fight and them knowing their status, they like biting others with the intention of infecting them." (Intw 4)

"… not a nice situation. It's like you will be standing there hopelessly screaming at them (MHCUs who are fighting)*, at times the situation get out of control, you find other patients separate those who are fighting … knowing that there is not much that you can do to help. One is also anxious, because you might infect yourself in the process." (Intw 5)*

"The worse thing is in the process you might be infected with the HIV virus …Every time when they start their fight you have to protect yourself from being infected." (Intw 6)

"To be honest, we nurses are very afraid of being infected." (Intw 8)

Fear of occupational exposure to HIV is widespread among nurses as they are aware that their jobs place them at risk of HIV infection. The fear might be based on real risks due to inadequate access to universal precautions, such as gloves and safe sharp disposal procedures (Kgosimore, 2016: 10). Anxiety over safety practices and occupational susceptibility increase nurses' burden of care (Asuquo, Adejumo, Etowa & Adejumo, 2013: 231). The chronic nature of HIV with death as amendatory outcome produces anxiety over safety practices and fear of occupational contagion among nurses (Asuquo *et al.*, 2013: 231).

A study done by Giandinoto and Edward (2014: 729) revealed that the fear of psychiatric nurses may lead to negative emotions due to the perceived risk of contracting HIV infection as

a result of accidental or intentional exposure to blood or body fluids of infected patients. The same study confirmed that providing care to patients with comorbid mental illness who are suicidal and have self-harming behaviours, aggression and confusion can evoke a sense of caution in nurses due to the real or perceived threat of their own safety. This fear, in turn, may negatively impact psychiatric nurses' ability to engage in ethical practice and to maintain a therapeutic relationship with MHCUs (Giandinoto & Edward, 2014: 729).

3.4.1.2 Fear of being attacked by MHCUs

The participants indicated that MHCUs often behave in violent ways, sometimes for no apparent reason. In the process the nurses might get hurt trying to calm them down or trying to stop the conflict. MHCUs might sometimes respond with revengeful behaviour and hurt the nurses when they intervene. Most of these nurses sustained injuries during violence and some had permanent injuries. These experiences were expressed as follows:

"I can't sit down with them, because I am afraid that they might harm me." (Intw 2)

"They can target you and harm you … they can bite you, or even beat you." (Intw 4)

P: "Those patients are very clever, you know. One incident that I will not forget: I was doing rounds with the doctor and the doctor asked the way forward with the patient, and after the rounds the patient started to accuse me of denying him leave and was threatening me.
R: "How does it make you feel?"
P: "Afraid, restless and like being unsafe." (Intw 5)

"These patients fight a lot and nurses' responsibility is to intervene, and is not just a small fight, they fight with everything. They can use chairs to beat each other, they break windows and they can also sharpen things like spoons to use as a weapon and use it on each other. You as a nurse need to intervene, and in the process, you may get hurt." (Intw 6)

MHCUs may present with aggressive behaviour and this can lead to fear of being injured. Mental health providers view working with MHCUs as entering an unsafe world, because they experienced negative emotional reactions and attitudes, and, consequently, may compromise the quality of nursing care. Nurses, as compared to other health-care providers, are at a high risk of experiencing work place violence that is initiated by patients (Stevenson, Jack, O' Mara

& LeGris, 2015: 1). Another study (Baby, Glue & Carlyle, 2014: 647) confirmed that direct violence from MHCUs includes punching, shoving, hitting, kicking, spitting, biting, scratching, using a weapon like a gun or edged weapon or blunt object, and rape. Assault by MHCUs to health providers are both a realty and a concern as the effects of violence can be devastating (Anderson & West 2011: 34.).

Work place violence causes intolerance between the victim and the perpetrator, because the victim can be stigmatised and the consequences very costly. The greater anticipated stigmatised identity were related to psychological distress (Overstreet & Quinn, 2014: 109). The fear of being attacked is prominent among psychiatric nurses. A nurse may be psychologically or physically affected. Psychologically this includes feelings of anger, anxiety, guilt, self-blame and shame. Physically it includes injuries and temporary or permanent disability (Stevenson, Jack, O' Mara & LeGris, 2015: n.p).

3.4.2 Experiences of aggressive behaviour of MHCUs living with HIV/AIDS

The second category formulated was "experiences of aggressive behaviour of MHCUs living with HIV/AIDS". The following subcategories emerged from this category: lack of insight into condition by MHCUs, aggressive outburst of MHCUs place professional nurses at risk, intentions to resign due to stress of caring for MHCUs and emotional turmoil in caring for MHCUs living with HIV/AIDS.

3.4.2.1 Lack of insight into condition by MHCUs

Participants indicated that the MHCUs seems not to understand much about their illness and treatment, hence they sometimes refuse to take medication as prescribed. Mental health care users often lack insight as a direct result of their mental illness. With regards to HIV testing, MHCUs in the setting undergo HIV counselling before and after testing. A failure to take HIV treatment as prescribed has a major impact on the health of the individual. The participants' opinions were expressed as follows:

"They don't have insight about their conditions, so it makes our lives and their lives at risk or my life as a nurse at risk." (Intw 3)

"Even the taking of medication they think is not important … they don't see the importance of taking medication … it makes life difficult to all of us and family of users. The majority is non-

compliant … they will take their medication for a certain period and when they relapse they stop taking medication and in the process they develop resistance to the treatment." (Intw 3)

"You will find that they don't even understand their condition … they don't even want to take their medication. They don't understand why they must take it." (Intw 4)

"My work situation is very risky … very frustrating, because it seems like the patients themselves don't understand the risk … Mentally ill patients don't take their HIV status very serious. They will just stop taking medication and this is worrying me." (Intw 5)

Lack of in insight refers to impaired awareness of illness (Torrey, 2017: 1). Another study concluded that the unawareness of illness is a direct consequence of a person's brain dysfunction and the person not believing he or she is ill. From this perspective, insight is thought of as a delusion of health. A specific type of delusion wherein the individual with schizophrenia denies the presence of a mental illness even in the face of obvious evidence of interference with daily functioning (Basu & Chakraborty, 2010: 18). Another study sees lack of insight as one of the most common symptoms in schizophrenia and may be associated with reduced quality of life, poor treatment adherence, increased number of hospitalisations and poor social cognition (Jansson & Nordgaard, 2016: 223).

3.4.2.2 Aggressive outbursts of mental health care users place nurses at risk

The participants felt that the aggressive behaviour displayed by MHCUs can place a nurse's life at risk, because the MHCUs' aggressive outbursts are associated with kicking, biting, scratching, swearing, screaming and breaking property and windows. These experiences were expressed as follows by participants:

"They are very aggressive. They can bite, scratch or beat you. They can also threaten you or swear at you in front of other nurses." (Intw 2)

"They put other people's life at risk when they fight – they like to bite, which is a very dangerous thing. They can infect you or other users." (Intw 3)

"If a patient is paranoid and suspects you were talking about him/her, they can target you and harm you. They can bite you, or even beat you. They can do anything that they think can infect

you. So, sometimes you end up not knowing if they are doing it out of their full senses or if it is because of their mental illness." (Intw 4)

"These people fight each other, they bite each other and you as a nurse need to intervene, and in the process, and you may get hurt. Every time when they start their fights you have to protect yourself from being infected." (Intw 6).

Nurses are at higher risk of experiencing violence in the workplace that is initiated by patients (Stevenson *et al.*, 2015: n.p). The same authors extend by saying that psychiatric nurses report among the highest violence and victimization rates of all types of nurses. The same study done in Canada has reported that almost one third of nurses working in direct-care hospitals or long-term care facilities reported a physical assault by a patient in the last 12 months (Stevenson, *et al.*, 2015: n.p). Workplace violence is a complex, dangerous and global occupational burden for the nursing profession and workplace violence in nursing remains unacceptably high (Kennedy & Julie, 2013: 1). Psychiatric nurses working with MHCUs presenting with acute symptoms work in a complex environment. This environment is characterized by MHCUs, who may present with a history of violence, sexual assault and substance misuse (Ngako *et al.*, 2012: 1).

3.4.2.3 Intention to resign due to stress of caring for MCHUs

Participants verbalised that sometimes they feel like resigning from their work place due to the high-risk behaviour they are facing. These views are expressed as follows:

"This can lead you of thinking to resign, because these MHCUs are dangerous and in the process, you can be infected with HIV." (Intw 2)

"Sad and bad and feel as if you can just leave psychiatric nursing in terms of exposing yourself to unnecessary diseases. Just leaving for a place where one will not be exposed to such risk." (Intw 3)

"… afraid, hopeless and even confused, sometimes I think of resigning and to look for a better place …" (Intw 6)

"I wish I could resign, imagine coming to work facing a life-threatening situation, is not good at all." (Intw 7)

A study done in Nigeria revealed that HIV has a psychological impact on nurses. Their working life is transformed to that of stress and anxiety about fear of injury and this will affect their family life with feelings of hopelessness and guilt (Asuquo *et al.*, 2013: 231). Stress among nurses is associated with resignations. The stress can also be caused by overcrowded wards without possibilities to maintain confidentiality for the MHCUs. Additionally, nurses experience stress due to lack of resources, such as enough staff. This created feelings of powerlessness since nurses are not able to give care to or comfort the patients to the extent that they would want to, even though they see and acknowledge their suffering (Erkki & Hedlund, 2013: 3).

According to a study done by Stevenson *et al.* (2015: n.p) violence can cause physical injuries that might cause high staff turnover, difficulty with retention of nurses, decreased morale, hostile work environment, nurses' absenteeism, more frequent medical errors, more workplace injury claims, greater costs due to disability leave and reduced quality of patient care. The same study states that MHCUs' aggression has an impact on professionals' psychological adjustment, producing physical, psychological and economic consequences for nurses. Dealing with violence and aggression can be stressful, particularly if nurses feel inadequately trained to deal with it (Ismail, 2016: 26).

3.4.2.4 Emotional turmoil in caring for MHCUs living with HIV/AIDS

Participants experienced emotional turmoil characterised by feelings of frustration, fear, confusion and anger. These feelings were expressed as follows:

"I feel very bad and confused, sometimes frightened …" (Intw 2)

"The problem is when you knock off being exposed to such a situation, they haunt you while at home. You know you must wake up going back to the same situation, facing patients who maybe beat you … It can affect you mentally, emotionally and physically". (Intw 3)

"I was always stressed at home, especially with the long hours and shortage of staff. After you have arrived at home you don't want anything, you are very irritable to everybody at home. The screaming and noise and fights make you physically, mentally and emotionally tired." (Intw 4)

"Afraid, hopeless and even confused …" (Intw 6)

"Very angry, frustrated, unsafe …" (Intw 9)

Exposure of psychiatric nurses to MHCUs living with HIV/AIDS leaves them in emotional turmoil. They feel frustrated and others may resign or develop negative behaviour such as being absent from work or discriminating against MHCUs (d'Ettorre & Pellicani, 2017: 337). Another study (Giandinoto & Edward, 2014: 729) reveals that the nurses experienced negative emotions due to perceived risk of contracting HIV infection as a result of an accidental or intentional exposure to blood or body fluids of infected patients. This, in turn, negatively impacted the ability to engage in ethical practice and maintain a therapeutic relationship with these patients. MHCUs can display unusual behaviours evoking a sense of caution in health professionals due to the real or perceived threat of their own safety, or the situation may be outside of their scope of practice, expertise or knowledge (Giandinoto & Edward, 2014: 729). A study done by Stevenson, Jack, O'Mara and LeGris (2015: 13) revealed that the psychological outcomes of violence in the work place may include anger, fear or anxiety, post-traumatic stress disorder symptoms, guilt, self-blame and shame.

A study done in Nigeria revealed the social, physical, psychological and emotional impact of caring for patients with HIV increases the burden of caregivers and portray them as targets of HIV-related prejudice (Asuquo *et al*., 2013: 232). Another study revealed that prolonged involvement in emotional demanding situations results in gradual progression towards emotional exhaustion, depersonalisation and reduced personal accomplishment, as well as commitment to one's profession (HIV Clinicians Society, 2013: 1).

3.4.3 Experience of difficulties in caring for MHCUs living with HIV/AIDS

The third category identified was "experience of difficulties in caring for MHCUs living with HIV/AIDS". The following subcategories emerged from this category: lack of support from management, attitudes of personnel towards HIV positive MHCUs and duty to care.

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3.4.3.1 Lack of support from management

The participants indicated that personnel do not get much support from management. When an incident occurs, management blames the personnel involved. The psychiatric hospital has a policy on handling of aggressive MHCUs. When an aggressive incident occurs, staff must

follow the steps as set out in the policy. Security officers are also called to assist the staff, although they are not based in the wards. The management may refer nurses to the wellness centre and if there is a need to take prophylactics, they will motivate for that. Management do not give much support on an emotional level, according to the participants. These opinions were expressed as follows:

"I mean management always shift blame to nurses, they will tell you that you were supposed to assess your MHCUs and prioritised …" (Intw 2)

"They will blame you …did you approach users properly? You will be a product of being blamed. There is not much support, although you will get counselling before getting prophylactics or if taken to wellness centre where you will get a word of encouragement." (Intw 3)

"They always want something that they can blame you on. For them to be supportive, they want the wrong …" (Intw 4)

"… Patients were fighting, and one was HIV positive. One of my colleagues was bitten on the arm and had to undergo the procedure of prophylactic treatment. He resigned after that incident … the management was not supportive to him, instead he was being blamed for the way he acted and there was nothing he can do as he was trying to help. The thing is that he was coming to relieve in our ward as there was a shortage of staff. The staff in my ward were always absent as they were not feeling safe around that patient and the management was doing nothing" (Intw 4)

"… our managers are not of much help, they are only looking at our mistakes. Management does not support us, they only intervene when the patients are affected …" (Intw 7)

A study done by Mokoka, Oosthuizen and Ehlers (2010: 1) revealed that verbal abuse from managers must be stopped, so that nurses remain in their jobs. Support in the workplace develops when positive relationships are built, where there is mutual respect, trust and integrity. The work environment needs to be friendly and supportive and the workplace must have a welcoming atmosphere. Nurses want to be appreciated and respected by management and want their expertise to be recognised, and to participate in decision-making processes pertaining to patient care. Sayed and Ali (2017: 43) supported that nurses should be able to

use decision-making skills to provide safe and effective nursing care. Papathanasiou, Fradelos Kleisiaris, Tsaras, Kalota and Kourkouta (2014: 405) found that empowerment of personnel and participation in decision making has being proven by various studies to correlate with reduction of burnout. Feather and Ebright (2013: 63.) stated that a supportive environment is one of the factors mostly associated with job satisfaction of nurses and emphasised that the nurse manager's role is important in structuring the type of environment that is critical for work satisfaction and retention of nurses.

3.4.3.2 Attitudes of personnel towards HIV positive MHCUs

The participants indicated that nurses tend to pass judgment to MHCUs who are HIV positive. Nurses think that MHCUs are careless and reckless and may discriminate towards MHCUs. These opinions were expressed as follows by participants:

"The majority of them can utilize anger, like I'm going to do this and that to a nurse, or they can initiate a fight as to bite you intentionally or spit saliva on you … they do it purposefully … very few patients will do the act out of innocence …" (Intw 3)

"There are still nurses who are discriminating against these patients. Others are avoiding them…" (Intw 4)

"Most of us (nurses) turn to judge patients who are infected as being careless, like they sleep around not using protection. We turn to forget that their thinking and reasoning is not the same as ours." (Intw 8)

The participants indicated that there are still nurses who do not want to provide care to MHCUs who are HIV positive. They will come up with plans to avoid caring for these patients. Some nurses will say they are sick, and others will just absent themselves. These views were expressed as follows:

"Troublesome patients, they don't cooperate at all. They actually demand more attention. I'm tired of them, because it looks like we send them to collect the diseases, hence they demand attention." (Intw 7)

"Nurses will refuse to attend to the patient, being afraid that they might be infected. I will check the delegation for the next day and when I'm on duty the next day, I will absent myself." (Intw 7)

"Full of hatred towards the patients." (Intw 9)

A study done in Nigeria by Asuquo *et al*. (2013: 232) revealed that caregivers can be portrayed as targets of HIV related prejudice and discrimination. Stigma originates from the shame, fear and silence that shape negative perceptions of people living with HIV and the behaviour thought to be associated with HIV transmission (Kgosimore, 2016: 1). The social impact emanates from the stigma associated with HIV, and caregivers are stigmatised as harbouring the HIV virus themselves besides caring for the sick. The fear of susceptibility to HIV through occupation has created unfavourable attitudes among nurses and is a constant issue of concern (Asuquo *et al*., 2013: 231).

Reports of unfavourable attitudes of health workers towards HIV patients indicated that personal behaviour puts health workers at risk much more than occupational contagion, yet the need to eliminate these feelings of susceptibility becomes the panacea that will improve quality of care (Asuquo *et al*., 2013: 232). Sometimes nurses themselves are stigmatising MHCUs with HIV/AIDS by talking negatively about the patients, labelling them or avoiding them. These behaviours by nurses may impact the development of effective therapeutic alliances (Giandinoto & Edward, 2014: 728). The general public may perceive people who experience mental illness as strange, frightening, unpredictable, aggressive and lacking self-control. Mental illness is associated with negative stereotypes such as being violent and dangerous, and these stigmatising notions can also be found in health professionals (Giandinoto & Edward, 2014: 728).

3.4.3.3 Duty to care

The participants' perceptions were regardless of how MHCUs behave – there are still patients, mothers, sisters and brothers and they still have needs like any other, i.e., a need to be treated with respect and a need for encouragement. Nurses also need to advocate for MHCUs and be non-judgemental. The participants expressed their ideas as follows:

"I think I learn to realise and except the situation. It taught me about respect. Not to be judgmental." (Intw 3)

"They need someone who understands them, not judging or discriminating them. They are very sensitive and paranoid … I once nursed a patient who was very paranoid, if she sees people talking, she thinks they are talking about her." (Intw 4)

"All I can say we need to advocate for patients." (Intw 5)

"But at the same time somebody must be there for the patients, we can't all be in general hospitals. MHCUs also need us". (Intw 6)

''Continuous health education and encouraging the MHCUs can help, without judging them.'' (Intw 6)

Psychiatric nurses still have a duty to care for MHCUs even if they are aggressive (Asuquo *et al*., 2013: 232). The task of the nurse is to give adequate information and support adherence to therapy. The nurses' ethical code states that the general responsibility for nurses is to provide care, including preserving health and preventing illness as well as suffering. Patients need to be shown compassion and integrity of information given by patients should be handled confidentially. Nurses should contribute to an ethical environment and should challenge unethical settings or practices (Erkki & Hedlund, 2013: 3). A study done by Sobekwa and Arunachallam (2015: 1) showed that most participants felt that recovery of MHCUs was a reward for their work despite the challenging circumstances they worked under.

3.4.4 A need for support in caring for MHCUs living with HIV/AIDS

The fourth category identified was 'a need for support in caring for MHCUs living with HIV/AIDS'. The following subcategories emerged from this category: Recommendations for support of psychiatric nurses and recommendations for support of MHCUs.

3.4.4.1 Recommendations for support of psychiatric nurses

There was a need expressed in this study for management to provide support to psychiatric nurses by addressing their issues and improving their work conditions. The psychiatric nurses in this study expressed a need for continuous professional development. They are also in need of moral support from management and a platform where management meet with nurses on a regular basis to voice their needs and frustrations. Additionally, they need teamwork from the

multidisciplinary team. Participants expressed a need to address shortage and absenteeism of staff, and for the institution to train them on handling aggressive MHCUs.

- **Continuous professional development**

The psychiatric nurses in the study expressed a need for ongoing training in handling aggressive MHCUs to improve the outcomes:

"… there is a gap of knowledge regarding taking care of MHCUs, who are HIV positive … more training is needed to psychiatric nurses to empower them with skills and knowledge." (Intw 1)

"… training is needed and more focus on handling of aggressive users and techniques to use; nurses need to be exposed to continuous training.'' (Intw 3)

"We all need ongoing training.'' (Intw 5)

"To give us in-service training, they must empower us.'' (Intw 8)

"Increase the number of in-service training''. (Intw 9)

In-service training about management of aggression needs to be provided, debriefing sessions to deal with burnout needs to be arranged and research to quantify levels of burnout should be conducted (Sobekwa & Arunachallam, 2015: 1).

- **Teamwork/support for each other**

The psychiatric nurses recommended teamwork among nurses, as well as among the multidisciplinary team. The participants also recommended climate meetings to raise their concerns and debriefing sessions. Giving a full report of each patient is a necessity at an early stage, as this can help to detect if the condition of the patient is changing. This can prevent the number of injuries that occur in the psychiatric wards. The following quotes illustrate this finding:

"Yes, there is a way, every month there is a climate meeting where we raise our voices, most often they will say they will come back to us, but they actually never do". (Intw 2).

"I think if they can increase the nurses and ensure team work, and ensure that they work

properly, maybe the care and interaction will improve." (Intw 2)

"I mean like when you do things we do together when we discuss about the patient, you do as team and with consistency." (Intw 3)

"The most important role (from management) *to be supporting is a debriefing session to voice out anger and frustration." (Intw 3)*

''One important thing for us, nurses is to support each other.'' (Intw 6)

"We could be given motivational speakers to help uplift our spirit during working hours." (Intw 6)

''Team work and giving each other a full report can help. Also to check and alert each other if a patient is relapsing and to inform the doctor to get the right treatment for that.'' (Intw 8)

A study done by Sobekwa and Arunachallam (2015: 1) revealed that nurses felt unappreciated and unsupported by authorities. The work environment needs to be friendly and supportive and the workplace must have a welcoming atmosphere. Nurses want to be appreciated and respected by management, they want their expertise to be recognised and to participate in decision-making processes pertaining to patient care.

In delivering health care, effective teamwork can immediately and positively affect patient safety and outcomes. The need for effective teams is increasing due to increasing co-morbidities and increasing complexity of specialisation of care (Babiker *et al.*, 2014: 9). Knowledge and expertise in teamwork that stem from different disciplines can be complementary and enriching and bring great benefits and potentially positive outcomes to clients, teams and the whole organisation. However, little has been written and reported on the barriers and risks that stem from a multidisciplinary teamwork approach (Roncaglia, 2016: 15). Another study done by O'Connor *et al.* (2016: 339) emphasises effective teamwork between health-care professionals as a critical element of patient safety and quality of care.

3.4.4.2 Recommendations for support of MHCUs

The participants in the study stated that since there is HIV/AIDS, psychiatric nursing has changed and there is a need to adapt in order to meet or to provide quality care. There is a

need for a specialised unit in a psychiatric hospital for patients with physical illness, such as HIV/AIDS, due to their vulnerabilities. The psychiatric nurses also expressed the need to educate the families about mental illness and HIV/AIDS and the importance of support and mental health education for MHCUs in order to encourage compliance with treatment. The following quotations provide evidence:

“The main important thing is to keep on educating users about disease itself … teach importance of taking medication, abstain from fighting one another … also to educate the family, because they spent time with the users. To educate family to be more supportive to the users … To give health education about the medication … Understand their mental status, also involve the family.” (Intw 3)

“… that there are needs of a specialised unit in a psychiatric hospital whereby patients with chronic physical diseases will be grouped together and admitted in that unit …” (Intw 4)

“Involve family or guardians.” (Intw 5)

“Maybe to meet once a week with patients and do prayer meetings, to talk to those, also to provide support, maybe they are being aggressive, because they feel rejected by staff … continuous health education and encouraging the MHCU can help, without judging them …” (Intw 6)

“Personally, I think HIV/AIDS patients need to have a special place to be taken to when they are sick like TB patients are taken to SANTA, orphans to a place of safety, mentally sick patients go to mental health institutions, HIV/AIDS patients also need to have a facility which will cater for their own needs.” (Intw 7)

According to the study done by the HIV Clinicians Society (2013: 155) all MHCUs should be offered HIV testing, HIV prevention/risk reduction education and access to condoms. Education, skills training and therapeutic counselling for caregivers affect how they perceive their burden, quality of life, coping skills and knowledge while lowering their levels of depression and distress (Berry *et al.*, 2017: 35). They need education about mental illness, training in effective caregiving and strategies, as well as the information of self-help groups in the community (Mokgothu, du Plessis & Koen, 2015: 1).

3.4 CONCLUSION

The findings and literature control upon which this research is based were discussed. Data from the interview transcripts were grouped into four main categories. These were subdivided into subcategories. Each category was discussed by using verbatim quotations in italics. Literature discussion was used to support each subcategory. The guideline development and validation, as well as the guidelines will be discussed in Chapter 4.

CHAPTER 4: DEVELOPMENT AND VALIDATION OF GUIDELINES TO ENSURE EFFECTIVE CARE TO MHCUS LIVING WITH HIV AND AIDS

4.1 INTRODUCTION

In the previous chapter, the findings of the study and the literature control were discussed. In this chapter, the development and refinement of the guidelines of the study will be discussed.

The first objective of the research was to explore and describe psychiatric nurses' experiences of providing care to MHCUs living with HIV/AIDS in a public psychiatric hospital. This was elaborated on in Chapter 3. The second objective of the research was to develop guidelines based on psychiatric nurses' experiences. The guidelines were developed for nursing management to ensure effective care to MHCUs living with HIV and AIDS.

4.2 GUIDELINE DEVELOPMENT METHODOLOGY

The draft guidelines were developed by the researcher in accordance with and guided by the following: discussion of findings and literature review (Chapter 3) and guiding attributes in the guideline development process as discussed in this section.

4.2.1 Summary of main findings

Data from the interview transcripts were grouped into four main categories: experiences of fear caring for MHCUs living with HIV/AIDS; experiences of aggressive behaviour of MHCUs living with HIV/AIDS; experiences of difficulties in caring for MHCUs living with HIV/AIDS and a need for support in caring for MHCUs living with HIV/AIDS. These were subdivided into subcategories.

Participants experienced emotional turmoil characterized by feelings of frustration, fear, confusion and anger. They indicated that they are not able to do their work to their best ability, because they are afraid they might be infected while busy providing care to MHCUs. According to the finding these participants did not feel free to intervene with these MHCUs, because they think some of the MHCUs have intentions of infect them. They indicated that MHCUs often behave in violent ways, sometimes for no apparent reason. In the process the nurses might

get hurt trying to calm them down or trying to stop the conflict. Most of nurses sustained injuries during violence and some had permanent injuries.

The findings also indicated that the MHCUs seemed not to understand much about their illness and treatment, hence they sometimes refuse to take medication as prescribed. The MHCUs not only displayed a lack of insight into their psychiatric problems, but also with regards to the HIV diagnosis resulting in a lack of compliance with their treatment regimens.

Participants also verbalized that they sometimes feel like resigning from their work due to the high risk behaviour they are facing. They feel it is better to leave psychiatric practice than to stay there and expose themselves to risk of being injured and infected. Participants revealed that they often feel negative towards MHCUs living with HIV/AIDS and avoid working with them, especially if they know that the MHCU has aggressive tendencies.

The psychiatric nurses in the study expressed their disappointment with the support provided from management. They expressed a need for ongoing training in handling of aggressive MHCUs, so as to improve the outcomes. There is a need to remove stigma in mental health and HIV by educating nurses. There is also a need to provide support to psychiatric nurses by addressing their issues and improving their work conditions. Psychiatric nurses also need teamwork from the multidisciplinary team to assist them with management of MHCUs.

4.2.2 Guiding attributes in the guideline-development process

The attributes that guided the researcher throughout the guideline development process were derived and adapted from the AGREE II instrument (Brouwers, Kho, Browman, Cluzeau, Feder, Fervers, Hanna & Makarski on behalf of the AGREE Next Steps Consortium (2013) and the Institute of Medicine (2010: 214–228). The guiding attributes were rigour, clarity, flexibility, applicability, stakeholder involvement and scope and purpose.

4.2.2.1 Rigour: validity and reliability

The rigour of the guidelines relates to the process used to gather and synthesize the evidence, and the methods to formulate and update the guidelines (Brouwers *et al*., 2010: 10). As recommended by Brouwers *et al*. (2010: 22), the following criteria were used to ensure rigour of the guidelines: systematic methods were used to search for the evidence and the evidence is clearly described in Chapter 3. The strengths and limitations of the study is described in

Chapter 5. The link between the guidelines and the supporting evidence is indicated in Table 4.1. The guidelines were externally reviewed by experts prior to its publication. The Delphi panel were asked to rate the guidelines in terms of validity: Guidelines will facilitate effective care to MHCUs living with HIV and AIDS; and reliability, given the same circumstances psychiatric nurses would interpret and apply the guidelines similarly. A procedure for updating the guidelines is provided at the end of this chapter.

4.2.2.2 Clarity

The clarity of the guidelines deals with the language, structure, and format of the guidelines (Brouwers *et al*., 2010: 10).

As recommended by Brouwers *et al*. (2010: 31), the following criteria were used to ensure clarity of the guidelines: The guidelines are specific and unambiguous, the different options for management of the MHCUs living with HIV and AIDS are clearly presented, and the recommendations are presented in Chapter 4. The Delphi panel were asked to determine the extent to which the guidelines are precise, unambiguous, user-friendly and logic.

4.2.2.3 Flexibility

The Delphi panel was asked to comment on the flexibility of the guidelines (Institute of Medicine, 2011: 214–228) to ensure that the guidelines are flexible enough to be adapted to different practice settings. They rated the guidelines according to the following criterion: Guidelines will empower psychiatric nurses caring for MHCUs living with HIV and AIDS to implement changes as applicable and re-evaluate their practice.

4.2.2.4 Applicability

Applicability deals with the likely barriers and facilitators to implementation, strategies to improve uptake, and resource implications of applying the guideline (Brouwers *et al*., 2010: 10).

As recommended by Brouwers *et al*. (2010: 35), the following criteria were used to ensure applicability of the guidelines: The guideline describes facilitators and barriers to its application and actions on how the guidelines can be implemented (see section 4.3.1 – 4.3.7). The potential resources of applying the guidelines are set out at the end of this chapter. The Delphi panel rated the guidelines according to the following criterion for applicability: The target

population is clearly stated, namely, psychiatric nurses caring for MHCUs living with HIV and AIDS.

4.2.2.5 Stakeholder involvement

Stakeholder involvement focuses on the extent to which the guidelines were developed by the appropriate stakeholders and represents the views of its intended users (Brouwers *et al*., 2010: 10).

The Delphi panel included representatives of the group targeted for the guidelines, namely psychiatric nurses, advanced psychiatric nurses, health care professionals and other experts in the field of study. The guidelines were based on phase 1 of this study, which represents the psychiatric nurses' experiences. A review of the guidelines was recommended after development. The process of developing guidelines, the evidence used, assumptions made and participants involved were accurately documented and described.

4.2.2.5 Scope and purpose

The scope and purpose are concerned with the overall aim of the guidelines, the specific health questions, and the target population (Brouwers *et al*., 2010: 10).

The overall objectives of the guidelines are specifically described. The research questions covered by the guidelines are specifically described in Chapter 1. The population to whom the guidelines are meant to apply is described throughout the study (Brouwers *et al*., 2010: 14).

4.3 DRAFT GUIDELINES TO ENSURE EFFECTIVE CARE TO MENTAL HEALTH CARE USERS LIVING WITH HIV/AIDS

The findings as set out in Chapter 3 were grouped together into four main clusters that logically belonged together (see Table 4.1). These four clusters were: 1) issues related to psychiatric nurses caring for MHCUs living with HIV/AIDS; 2) issues related to MHCUs living with HIV/AIDS; 3) ways of coping of psychiatric nurses caring for MHCUs living with HIV/AIDS; and 4) psychiatric nurses' need for support in caring for MHCUs living with HIV/AIDS.

From cluster 1, two guidelines were derived, from cluster 2, two guidelines were also derived, from cluster 3, one guideline, and from cluster 4 two guidelines were developed. The guidelines were based on the findings, and on the appropriate literature as indicated in the

discussion following Table 4.1. Each of the seven guidelines are discussed in accordance with the rationale and certain actions recommended to implement the guideline.

Table 4.1: Development of guidelines to ensure effective care to mental health care users living with HIV/AIDS

Finding cluster 1: Issues related to psychiatric nurses caring for MHCUs living with HIV/AIDS
Attitude towards HIV positive MHCUs
Emotional turmoil in caring for MHCUs living with HIV/AIDS Fear of being infected by MHCUs Fear of being attacked by MHCUs
Guideline 1: Psychiatric nurses are provided with opportunities to develop self-awareness with regards to their attitudes towards MHCUs living with HIV/AIDS
Guideline 2: Psychiatric nurses are exposed to regular debriefing to identify, express and develop ways to cope with their emotional experiences (specific reference to fear) related to caring for MHCUs living with HIV/AIDS

Finding cluster 2: Issues related to MHCUs living with HIV/AIDS
Lack of insight into condition by MHCUs
Aggressive outbursts of MHCUs place nurses at risk
Guideline 3: Psychiatric nurses are capacitated to use therapeutic interventions to facilitate improved insight in MHCUs living with HIV/AIDS
Guideline 4: Psychiatric nurses receive managerial and interdisciplinary support in the management (prevention, de-escalation, intervention) of aggression in MHCUs living with HIV/AIDS

Finding cluster 3: Ways of coping of psychiatric nurses caring for MHCUs living with HIV/AIDS
Intention to resign due to stress of caring for MCHUs Duty to care
Guideline 5: Psychiatric nurses are provided with opportunities to reflect on and improve their ways of coping with the provision of care to MHCUs living with HIV/AIDS

Finding cluster 4: Psychiatric nurses' need for support in caring for MHCUs living with HIV/AIDS
Continuous professional development
Teamwork/support for each other
Guideline 6: Psychiatric nurses are capacitated with continuous professional development related the provision of care to MHCUs living with HIV/AIDS
Guideline 7: Psychiatric nurses are encouraged to develop peer support structures related the provision of care to MHCUs living with HIV/AIDS

4.3.1 GUIDELINE 1: Psychiatric nurses are provided with opportunities to develop self-awareness with regards to their attitudes towards MHCUs living with HIV/AIDS.

4.3.1.1 Rationale

Psychiatric nurses expressed negative attitudes towards MHCUs living with HIV/AIDS. Caregivers can be portrayed as targets of HIV-related prejudice and discrimination. Stigma originates from the shame, fear and silence that shape negative perceptions of people living with HIV and the behaviour thought to be associated with HIV transmission (Kgosimore, 2016: 1). HIV/AIDS and mental illness have common features. Both are complex, intractable diseases affecting marginalized communities throughout the life span, and both are shrouded in stigma and discrimination (Gostin, 2015: 689). The human suffering and social alienation caused by HIV/AIDS remain an urgent global threat. The social impact emanates from the stigma associated with HIV and caregivers are stigmatized as harbouring the HIV virus themselves, besides caring for the sick (Gostin, 2015: 689).

Sometimes nurses themselves are stigmatizing MHCUs with HIV/AIDS by talking negatively about the patients, labelling them or avoiding them. These behaviours by nurses may impact the development of effective therapeutic alliances (Giandinoto & Edward, 2014: 728). The fear of susceptibility to HIV through occupation has created unfavourable attitudes amongst nurses and is a constant issue of concern (Asuquo *et al*., 2013: 231). The effects of stigma are moderated by the knowledge of mental illness and cultural relevance. Understanding stigma is central to reducing its negative impact on care seeking and treatment engagement. (Corrigan, Druss & Perlick, 2014: 37)

The general public may perceive people who experience mental illness as strange, frightening, unpredictable, aggressive and lacking self-control. Mental illness is associated with negative stereotypes such as being violent and dangerous, and these stigmatizing notions can also be found in health professionals. Violence among people with serious mental illness can also be high, with epidemiological research suggesting frequencies that are 2.5 times that of the comparable demographic (Corrigan, Druss & Perlick, 2014: 39).

4.3.1.2 Actions

Psychiatric nurses should be provided opportunities such as workshops where they can learn how to reflect on their attitudes towards MHCUs living with HIV/AIDS. A facilitator trained in reflective techniques should present the workshop, guided by self-awareness and reflective techniques.

a) Self-awareness and reflection

Self-awareness is the ability to focus on the self and understand how your actions, thoughts or emotions do or do not align with your internal standards. It is a critical tool assisting psychiatric nurses reach higher levels of job satisfaction, become better leaders, improve relationships with colleagues and manage emotions better. It, therefore, correlates with higher levels of overall happiness (Forsey, 2018: 63). The following are actions that psychiatric nurses may practise to improve self-awareness:

- **Keep an open mind:** It involves the ability to regulate own emotions, be a team player and be open to others.
- **Be mindful of strengths and weaknesses**: Self-aware individuals know their own strengths and weaknesses. They are able to work from that space and be mindful to know when to reach out for assistance.
- **Stay focused:** This means making connections with people, avoid distractions and focus on the goal to be achieved.
- **Set boundaries:** A person needs to have strong boundaries in place, be sincere to others, but must also be able to say no when needed to say no. Boundaries help people to be serious about their work and their passions. One needs to be firm with boundaries to maintain the integrity of his/her goals.
- **Know emotional triggers:** This entails the ability to be able to identify one's own emotions as they are happening. A person must not repress emotions or deny their causes but must be able to be flexible. It also entails the ability to fully process emotions before communicating with others.
- **Embrace your intuition:** Trust your own instincts and take risks associated with them.
- **Practice self-discipline:** Be disciplined at work and in every area of life. It is characteristic of providing one with endurance (Fallon, 2014: n.p).

4.3.2 GUIDELINE 2: Psychiatric nurses are exposed to regular debriefing to identify express and develop ways to cope with emotional experiences (specific references to fear) related to care for MHCUs living with HIV/AIDS.

4.3.2.1 Rationale

Exposure of psychiatric nurses to MHCUs living with HIV/AIDS leaves them in emotional turmoil. They feel frustrated (d'Ettorre & Pellicani, 2017: 337) and experience negative emotions due to perceived risk of contracting HIV infection as a result of accidental or intentional exposure to blood or body fluids of infected patients. This in turn negatively impacts the nurses' ability to engage in ethical practice and maintain a therapeutic relationship with these patients (Giandinoto & Edward, 2014: 729).

Prolonged involvement in emotional demanding situations results in gradual progression towards emotional exhaustion, depersonalization and reduced personal accomplishment, as well as commitment to one's profession (HIV Clinicians Society, 2013: 155). The participants indicated that they are not able to do their work to their best ability because they are afraid they might be infected while providing care to MHCUs. Anxiety over safety practices and occupational susceptibility increases nurses' burden of care (Asuquo, Adejumo, Etowa & Adejumo, 2013: 231). The chronic nature of HIV with death as amendatory outcome produces anxiety over safety practices and fear of occupational contagion amongst nurses (Asuquo, Adejumo, Etowa & Adejumo, 2013: 231). Another study done by Giandinoto and Edward (2014: 728) also confirmed that providing care to patients with co-morbid mental illness and who are suicidal and have self-harming behaviours, aggression and confusion can evoke a sense of caution in nurses due to the real or perceived threat of their own safety. This fear, in turn, may negatively impact psychiatric nurses' ability to engage in ethical practice and to maintain a therapeutic relationship with MHCUs (Giandinoto & Edward, 2014: 728).

Mental health providers view working with MHCUs as entering an unsafe world, because of the negative experience of emotional reactions and attitudes and in the process compromising the quality of nursing care. Nurses, as compared to other health-care providers, are at a high risk of experiencing workplace violence initiated by patients (Stevenson, Jack, O' Mara & LeGris, 2015: 1). Workplace violence causes intolerance between the victim and the perpetrator due to the stigmatisation of the victim. The consequences can, therefore, be very costly (Overstreet & Quinn, 2014: 109). The fear of being attacked is prominent amongst psychiatric

nurses. A nurse may be psychologically or physically affected. Psychologically this includes feelings of anger, anxiety, guilt, self-blame and shame. Physically it includes injuries and temporary or permanent disability. MHCU violence might cause high staff turnover, difficulty with retention of nurses, decreased morale, hostile work environment, nurses' absenteeism, more frequent medical errors, more workplace injury claims, and greater costs due to disability leave and reduced quality of patient care. MHCUs' aggression has an impact on professionals' psychological adjustment, producing physical, psychological and economic consequences for nurses (Stevenson, Jack, O' Mara & LeGris, 2015: 1). Dealing with violence and aggression can be stressful, particularly if nurses feel inadequately trained to deal with the situation (Ismail, 2016: 26).

Participants verbalized that sometimes they feel like resigning from their workplace due to the high-risk behaviour they are facing. A study done in Nigeria revealed that HIV has a psychological impact on nurses. Their working life is transformed to that of stress and anxiety about fear of injury and this will affect their family life with feelings of hopelessness and guilt (Asuquo *et al.*, 2013: 231). Stress amongst nurses is associated with resignations. Nurses also experience stress due to lack of resources such as enough staff. These feelings create powerlessness since nurses are not able to give care to or comfort the patients to the extent that they would want to, even though they see and acknowledge their suffering (Erkki & Hedlund, 2013: 3).

4.3.2.2 Actions

Debriefing steps are recommended to help psychiatric nurses to identify, express and develop ways to cope with emotional experiences. There should be a therapeutic team or therapist (psychologist or advanced psychiatric nurse) assigned with the task of conducting debriefing with nurses as required.

a) Debriefing

Debriefing refers to a highly structured form of personal debriefing which can take place after a traumatic experience such as a violent incident. The goal is to educate people about the normal stress reactions and ways to cope with them to promote the expression of thoughts and feelings about the incident, to bring a sense of closure and provide information about how to access further support or help if required (Hawker, 2016: 2).

Seven steps of debriefing are recommended (Adapted from Snelgrove, 1999: n.p.):

- **Step 1: Pre-debriefing**
  - Gather relevant information regarding the critical incident.
  - Set logistics of time and location.
- **Step 2: Contact/contrast**
  Therapist introduce him/herself and create rapport.
- **Step 3: Story**
  The therapist invites the person to describe what happened before, during and after the incident occurred by asking open-ended questions.
- **Step 4: Impact**
  The therapist focuses on the feelings but use own discretion as for some people direct questions regarding their feelings might be threatening.
- **Step 5: Symptom education**
  - The therapist explains that the symptoms people are experiencing are common or typical reactions to a traumatic event; and
  - normalise the emotional experiences.
- **Step 6: Current functioning and coping**
  Create a coping plan together with participants.
- **Step 7: Follow up**
  - Ask if there is anything that participants want to talk about before the end.
  - Set follow-up time if needed.
  - Informally follow up within a week can also be done (Adapted from Snelgrove, 1999: n.p.)

4.3.3 GUIDELINE 3: Psychiatric nurses are capacitated to use therapeutic interventions to facilitate improved insight in MHCUs living with HIV/AIDS.

4.3.3.1 Rationale

Participants indicated that the MHCUs seem not to understand much about their illness and treatment, hence they sometimes refuse to take medication as prescribed. A failure to take HIV treatment as prescribed has a major impact on the health of the individual.

Lack of in insight refers to the impaired awareness of illness (Torrey, 2017: 1). Unawareness of illness is a direct consequence of a person's brain dysfunction and the person not believing his or her illness. From this perspective, insight is thought of as a delusion of health; a specific type of delusion wherein the individual with schizophrenia denies the presence of a mental illness, even in the face of obvious evidence of interference with daily functioning (Basu & Chakraborty, 2010: 18). Lack of insight is one of the most common symptoms of schizophrenia and may be associated with reduced quality of life, poor treatment adherence, increased number of hospitalizations and poor social cognition (Jansson & Nordgaard, 2014: 223).

There is a need to involve MHCUs more often into therapeutic sessions to instil knowledge and understanding about their mental illness and HIV/AIDS. There is also a need to emphasise the importance of taking treatment and, consequently, explain the implications of failure not to take treatment as prescribed. Lack of insight refers to impaired awareness of illness (Torrey, 2017: 1).

4.3.3.2 Actions

Therapeutic interventions (individual or group) are recommended to facilitate improved insight in MHCUs living with HIV/AIDS (Ezhumalai, Muralidhar, Dhanasekarapandian & Nikketha, 2018: S514; Stuart, 2017: 596).

a) Individual interventions

According to Stuart (2017: 22) the therapeutic nurse-patient relationship is divided into four phases, namely pre-interaction phase, orientation phase, working phase and termination phase. During each phase of the relationship process the nurse has a task that are stipulated as follows:

- **Pre-interaction phase:** Nurses explore their own feelings, fantasies and fears and analyse their own professional strengths and limitations. The first meeting is planned with the MHCUs. Information about MHCUs is gathered.
- **Orientation phase:** Nurses determine why MHCUs sought help, establish trust, acceptance and open communication. Patients' problems are identified, and goals defined.
- **Working phase:** Nurses explore relevant stressors, promote patients' development of insight and use of constructive coping mechanisms, and overcome resistance behaviours.

- **Termination phase:** Nurses establish reality of separation, review progress of therapy and attainment of goals and explore feelings of sadness and anger, and related behaviours.

b) Group interventions

During group interventions, the nurse observes and facilitates the development stages of the group as follows:

- **Forming:** Members became oriented toward each other, work on being accepted and learn more about the group. This is marked by a period of uncertainty in which members determine their place in the group and learn about group rules and procedures.
- **Storming:** Conflicts begin to arise as members resist the influence of the group and rebel against accomplishing their tasks. Members confront their various differences and the management of conflict often becomes the focus of attention.
- **Norming:** The group establishes cohesiveness and commitment in the process, and the members discover new ways to work together. Norms are also set for appropriate behaviour.
- **Performing:** The group works as a unit to achieve group goals. Members develop proficiency in achieving goals and become more flexible in their patterns of working together. The members desire to work together towards common goals (Stuart, 2009: 596).
- **Adjourning:** The group disbands. The feelings that members experience are similar to a separation stage. (Ezhumalai, Muralidhar, Dhanasekarapandian & Nikketha, 2018: S514)

4.3.4 GUIDELINE 4: Psychiatric nurses receive managerial and interdisciplinary support in management (prevention, de-escalation, intervention) of aggression in MHCUs living with HIV/AIDS.

4.3.4.1 Rationale

The participants indicated that MHCUs often behave in violent ways, sometimes for no apparent reason. In the process the nurses might get hurt trying to calm them down or trying to stop the conflict. MHCUs might sometimes respond with revengeful behaviour and hurt the

nurses when they intervene. Nurses caring for involuntary mental health-care users are faced with challenging situations while they themselves experience internal conflict and have limited choices available to be assertive. To strengthen their resilience, the following factors should be taken into account: support, training of staff, security and safety measures, and teamwork (Ramalisa, du Plessis & Koen, 2018: 1). When psychiatric nurses experience aggression, it affects their ability to perform as a team as well as their daily tasks and duties. When aggression is not acknowledged by not talking about it or addressing the source of aggression, the psychiatric nurses experience limited support from their colleagues and management who they see as part of the nursing team (Roets, Poggenpoel & Myburgh, 2018: 1)

Workplace violence is a complex, dangerous and global occupational burden for the nursing profession and workplace violence in nursing remains unacceptably high (Kennedy 2013: 1). Psychiatric nurses working with MHCUs presenting with acute symptoms work in a complex environment. This environment is characterized by MHCUs who may present with a history of violence, sexual assault and substance misuse (Ngako *et al.*, 2012: 1). MHCUs presenting with acute symptoms make challenging demands on the nurses (Fourie *et al.*, 2005: 135). These demands include maintaining unit safety, retaining supportive relationships with MHCUs presenting with acute symptoms, and attending to their emotional and physical needs (Ngako *et al.*, 2012: 1).

4.3.4.2 Actions

It is recommended that psychiatric nurses receive managerial and interdisciplinary support in management (prevention, de-escalation, intervention) of aggression in MHCUs living with HIV/AIDS. This support was recommended as follows according to Boyd (2018: 290).

a) Prevention

Prevention involves intervention which are done to prevent occurrence of the actual violent behaviour. The aim is to promote safety and prevent violence. Boyd (2018: 290) discusses prevention of violent behaviour based on impaired communication, physical conditions, social factors, and milieu and environmental factors.

- **Impaired communication:** Loss of hearing or reduced visual acuity, disorientation and depression are often associated with aggressive behaviour. Anticipation of basic needs, such as thirsty and hunger, is also important. These can be powerful stimuli of agitated

behaviour.

- **Physical condition:** Patients with longstanding poor dietary habits often has deficiencies of thiamine and niacin, as a result there may be increased irritability, disorientation and paranoia. Assessment of overall dietary intake is essential. Caffeine intake should be limited.
- **Social factors:** Crisis conditions in patients' home, family or community can lead to violent episodes. If assessment reveals stressful actions by family members, attention must be devoted to mobilizing resources for family and community support.
- **Milieu and environmental factors:** Anger or out of control behaviour may be influenced by contextual factors. Boyd (2018: 291) identified characteristics of unit culture and staff behaviour that can trigger patient's aggressive behaviour:
    - A busy, noisy hospital unit
    - Rude comments or staff denial of patients' requests
    - Rigid unit rules
    - Lack of patient privacy or boundary violations
    - Lack of patient control over the treatment plan
    - Patronizing behaviour of staff
    - Insufficient help with activities of daily living and other needs from staff
    - Lack of meaningful and predictable ward activities

b) De-escalation intervention

De-escalation entails talking with an angry or agitated service user in such a way that violence is averted, and the person regains a sense of calm and self-control (National Institute for Clinical Excellence, 2015: 30). The following are de-escalation techniques:

- maintaining a calm tone of voice, not shouting or verbally threatening the person;
- using non-verbal techniques;
- being aware of oneself;
- remaining calm;
- using non-threatening body language;
- having immediate access to the door of the room in case you need to leave the room; and
- respecting the patient's personal space and boundaries.

c) Intervention

Boyd (2018: 107) identified principles that need to be followed when handling a potential aggressive patient:

- The patient must remain the primary focus of the interaction.
- A professional attitude sets the tone of the therapeutic relationship.
- Self-disclosure should be used cautiously for therapeutic purposes only.
- Patient's confidentiality must be maintained.
- Patient's intellectual competence to test his/her level of understanding should be assessed.
- A non-judgemental attitude must be maintained.
- Advice must be avoided.
- Guidance of patient should be done rationally to re-interpret his or her experiences.
- Verbal interaction of the patient must be tracked by using clarifying statements.
- Overreaction should be avoided.
- Empathic response can reduce emotional arousal, because the patient feels understood and supported.
- Personal safety should be maintained.
- Onlookers must be removed.
- Non-verbal clues or threats must be looked out for.
- Two trained people talking to the patient are reducing the chance of aggressive behaviour (Spencer & Johnson, 2016: 1).

4.3.5 GUIDELINE 5: Psychiatric nurses are provided with opportunities to reflect on and improve their ways of coping with the provision of care to MHCUs living with HIV/AIDS.

4.3.5.1 Rationale

The participants felt that MHCUs still have needs like any other, namely a need to be loved and to be treated with respect. Psychiatric nurses still have a duty to care for MHCUs even if they are aggressive (Asuquo *et al.*, 2013: 232). The task of the nurse is to give adequate information and support regarding adherence to treatment and therapy. The ethical code for nurses states that the general responsibility of nurses is to provide care, including preserving

health and preventing illness, as well as suffering. The patients need to be shown compassion, and integrity of information given by patients should be handled confidentially. The nurses should contribute to an ethical environment and should challenge unethical settings or practices (Erkki & Hedlund, 2013: 3). A study done by Sobekwa and Arunachallam (2015: 1) showed that most participants felt that recovery of MHCUs was seen as a reward for their work, despite the challenging working conditions.

4.3.5.2 Actions

Psychiatric nurses should be provided with opportunities to reflect on and improve their ways of coping with the provision of care to MHCUs living with HIV/AIDS. These opportunities can take the form of workshops or group discussions. Boyd (2018: 441) identified coping strategies that focus on wellness challenges and cognitive techniques.

a) Wellness challenges

- **Do satisfying and enriching work** by choosing activities that are consistent with skills and knowledge.
- **Cope effectively with daily stresses without excessive worry** by developing a daily schedule, allowing time to relax, avoid multitasking**,** deep breathing and mindfulness techniques.
- **Incorporate physical activity, healthy food and adequate sleep** into daily life. Do regular physical activity, make a weekly menu of healthy meals, and establish healthy sleep hygiene routines.
- **Develop a sense of connection, belonging and support system** by joining a support group seeking out recreational activities with friends and families.
- **Expand a sense of purpose and meaning in life** by focusing on goals, values and beliefs, reading inspiring stories or essays.
- **Teach breathing control** to reduce or change the breathing pattern. Abdominal breathing can be used to interrupt an episode of panic before it starts.

b) Cognitive techniques (Boyd, 2018: 444)

- **Distraction** involves implementing distracting behaviour such as initiating conversation with a nearby person or engaging in physical activity.
- **Reframing** is a cognitive technique that can change the way a situation is viewed and

reduce the impact of anxiety provoking thoughts. Avoid use of ''should statements'' and identify positive aspects of work and other successes.

- **Positive self-talk** involves planning and rehearsing positive coping statements. Like ''I can handle this and this is only anxiety, it will pass''.

4.3.6 GUIDELINE 6: Psychiatric nurses are capacitated with continuous professional development related the provision of care to MHCUs living with HIV/AIDS.

4.3.6.1 Rationale

The psychiatric nurses in the study expressed a need for ongoing training in handling aggressive MHCUs to improve the outcomes. Ongoing training, education and professional development facilitate transition to practice for students and new graduates and help to ensure competency and quality patient care throughout the span of nurses' careers (Price & Reichert, 2017: 10). In-service training about management of aggression needs to be provided, debriefing sessions to deal with burnout needs to be arranged and research to quantify levels of burnout should be conducted (Sobekwa & Arunachallam, 2015: 1).

Training and education were directly linked to nurses' career satisfaction. Healthy work environments were identified by nurses as those that invested in continuing professional development opportunities to ensure continuous growth in their practice and provide optimal quality patient care (Price & Reichert, 2017: 1). Continuing professional development is the purposeful maintenance and improvement of a professional's knowledge and skills to remain competent in their chosen profession for their own benefit. It is recognised as a commitment to being professional, keeping up to date and seeking to improve. All practising nurses and midwives must complete 20 hours of continuous professional development per year that is relevant to their context of practice (Continuing Professional Resource Guide, 2017: 3). Nursing continuing education with development of knowledge, skills, and attitude results in the improvement of nursing activity and, consequently, helps to improve health care (Eslamian, Moeini & Soleimani, 2015: 378).

4.3.6.2 Actions

Psychiatric nurses should be provided with in-service training and programmes to improve their skills with the provision of care to MHCUs living with HIV/AIDS. Management should provide opportunities for ongoing in-service training and programmes.

In-service training can be presented considering Kolb and Fry's learning styles (Coetzee & Schreuder, 2016: 438) and the six key principles of adult learning **(**Coetzee & Schreuder, 2016: 438). Workplace programmes are also recommended (Muller, Bezuidenhout & Jooste, 2011: 226).

a) Learning styles

Converger

Use deductive reasoning extensively.

Prefers dealing with things as opposed to people.

Enjoys practically applying theory.

Possible learning facilitation strategy: On-the-job training, debriefing sessions and laboratory experiences.

Diverger

Involves imaginative and easily generates ideas.

Viewing things in different perspectives.

Interested in people and cultures.

Possible learning facilitation strategy: Case studies, discussions are real experiences.

Assimilator

Excel at creating theoretical models.

Strong in inductive reasoning.

More concerned with abstract concepts.

Work well in research and planning.

Possible learning facilitation strategy: Theoretical, buzz groups and sharing of content.

Accommodator

Strength lies in doing.

Tends to take risks.

Solve problems using intuition.

Perform well in action-orientated jobs.

Relies on others for information.

Possible learning facilitation strategies: Simulations, field trips, laboratories, practice sessions, and on-the-job training (Coetzee & Schreuder, 2016: 436).

b) Six key principles of andragogy (adult learning)

Motivation to learn

There might be a wide range of motives that induce individuals to participate in a given learning intervention.

Goal orientation

Learner learns what he/she needs to know based on the job requirements or stage in life where they find themselves.

Self-concept

Self-concept can vary from dependent personality who needs support and guidelines to a self-directing human being who is able to work independently.

Prior experience

The learner's attitude will be influenced by his/her previous experiences and readiness to learn. This is dependent on his/her stage of development and the social roles that he/she fulfils.

Orientation to learning

Orientation to learning involves the learning style that the learner is comfortable with. (Coetzee & Schreuder, 2016: 438).

c) Workplace programmes

Workplace programmes refer to formalised programmes for employees focusing on leadership, awareness, prevention, care, support and employee assistance. The objectives of a workplace programme (Muller, Bezuidenhout & Jooste, 2011: 226) are as follows:

- **Establish, maintain and improve an HIV/AIDS management system**
  - Ensure a safe and supportive working environment for all employees.
  - Comply with the international and national standards and codes of practice/conduct.
- **Prevention and awareness programme**
  - Education and awareness programmes regarding HIV/AIDS in the workplace.
  - Participatory education programmes, referred to as peer group education.
  - Programmes to facilitate behavioural change among MHCUs.
  - Occupational health and safety programmes for employees.
- **Treatment, care and support programmes**

  It should focus on wellness management, such as an employee assistance programme for employees including psychosocial support (Muller, Bezuidenhout & Jooste, 2011: 228).

4.3.7 GUIDELINE 7: Psychiatric nurses are encouraged to develop peer support structures related to the provision of care to MHCHs living with HIV/AIDS.

4.3.7.1 Rationale

The psychiatric nurses in the study expressed a need for continuous support from the nursing team and the multidisciplinary team. Team building among nurses and the multi-disciplinary team needs to be done more often to improve quality of care and support each other in an effective way.

In delivering health care, effective teamwork can immediately and positively affect patient safety and outcomes. The need for effective teams is increasing due to increasing co-morbidities and increasing complexity of specialization of care (Babiker *et al.*, 2014: n.p). Knowledge and expertise in teamwork that stem from different disciplines, can be complementary and enriching and bringing great benefits and potentially positive outcomes to clients, teams and organizations (Roncaglia, 2016: 15). Another study done by O'Connor *et al.* (2016: 339) emphasizes that effective teamwork between health-care professionals is recognized to be a critical element of patient safety and quality of care. Team building in the workplace is needed to strengthen the relationship between nurses and other team members. This is crucial for the quality of services.

There was a need expressed in this study for management to provide support to psychiatric nurses by addressing their issues and improving their work conditions. The psychiatric nurses in this study expressed a need for counselling and debriefing. They are also in need of moral support from management and a platform where management meet with these nurses on a regular basis to voice their needs and frustrations. They also need teamwork from the nursing and multidisciplinary team.

A study done by Sobekwa and Arunachallam (2015: 1) revealed that nurses felt unappreciated and unsupported by authorities. The work environment needs to be friendly and supportive and the workplace must have a welcoming atmosphere. Nurses want to be appreciated and respected by management and their peers and they want their expertise to be recognized and to participate in decision-making processes pertaining to patient care.

4.3.7.2 Actions

It is recommended that psychiatric nurses receive continuous support from one another in the nursing team as well as from the multidisciplinary team in order to improve work relationships, as well as quality of care. Muller, Bezuidenhout and Jooste (2011: 335) recommended the following regarding teamwork and team building:

a) Team building

A team is a unit of interdependent individuals with complementary skills and are committed to common purpose, goals and expectations (Muller, Bezuidenhout & Jooste, 2011: 335). The following factors were identified as characteristics of effective teams, team norms, team cohesiveness, team composition, team leadership and organisational support.

- **Team norms:** The accepted norms within the team influences the way in which members interact with one another, that is to take decisions and approach and solve problems.
- **Team cohesiveness and interdependence:** Factors that increase cohesion include shared purpose; it is the extent to which the team bonds together and remains committed to achieving team goals.
- **Team composition:** In order for a team to perform more effectively, the team must have the right mix of complementary skills, knowledge and ability.
- **Team leadership:** This can be done by modelling the desired behaviour through self-sacrificing behaviour, displaying confidence and going beyond what is expected.
- **Organisational support:** Effective teams are those that receive strong support from management in terms of the training, rewards, information and material resources they require.

4.4 GUIDELINE VALIDATION METHOD

A Delphi technique (Keeney, Hasson & McKenna, 2011: 3) was utilized to validate the draft guidelines of this study. Different perspectives and opinions on the draft guidelines were obtained from a panel of experts. The researcher analysed and summarised the panel members' views. A consensus rate of 78% was obtained. This rate was deemed adequate based on a systematic review by Diamond, Grant, Feldman, Pencharz, Ling, Moore and Wales (2014), who determined that the most common definition for consensus was percent

agreement (25 Delphi studies), with 75% being the median threshold to define consensus. The Delphi technique is discussed in accordance with the method followed: selection of participants; inclusion criteria, and Delphi round (including data collection and analysis). The ethical considerations are covered in Chapter 1.

4.4.1 Selection of participants

The researcher selected participants from experts in the field of HIV/AIDS and psychiatrics from public and private health sectors. A list of potential participants was developed and participants were purposively selected. The researcher selected and invited experts as potential participants in accordance with the inclusion criteria (Chapter 2, 2.6.2.2). Fifteen of these potential participants responded and participated in the Delphi.

Table 4.2 provides a summary of the professional qualifications, occupations, employment and experience in the field of HIV/AIDS and psychiatry, for each participant.

Table 4.1: Descriptive information of the Delphi-technique participants

No	Professional qualifications	Occupation	Employer	Experience in the field in years
1	Medical officer	Registrar	Psychiatric hospital (public)	10
2	Bachelor of nursing Master's in nursing	Advanced psychiatric nurse	Psychiatric hospital (public)	7
3	Bachelor of nursing Master's in nursing	Nursing manager	Psychiatric hospital (public)	10
4	Bachelor of nursing Master's in nursing	Advanced psychiatric nurse.	Psychiatric hospital (public)	14
5	Bachelor of nursing	Professional nurse	Mediclinic (private hospital)	7
6	Diploma in advanced psychiatry	Professional nurse	Psychiatric hospital (public) Department of Health	**15**
7	Advanced diploma in occupational health	Occupational nurse	Psychiatric hospital (public) Department of Health	**7**
8	Diploma in advanced psychiatry	Professional nurse	Psychiatric hospital (public) Department of Health	**8**
9	Diploma in primary health	Professional nurse	Aids Health Foundation	**10**
10	Bachelor of nursing Master's in nursing	Advanced psychiatric nurse	Department of Health, head office	**10**
11	Diploma in nursing	Professional nurse	Psychiatric hospital (public)	**15**
12	Diploma in nursing	Professional nurse	Department of Health, head office	**13**
13	Diploma in nursing	Professional nurse	Department of Health, head office	**10**
14	Diploma in nursing	Professional nurse	Psychiatric hospital (public)	**23**
15	Diploma in nursing	HIV Coordinator	Maisha Medical (medical insurance sector)	**9**

4.4.2 Delphi round

Data collection and analysis are discussed for the Delphi round.

4.4.2.1 Data-collection method and instrument

Selected participants were contacted by e-mail and personally by the researcher through a cover letter explaining the objectives of the Delphi and the conditions of participation. An instrument to validate the guidelines, a cover letter including instructions, deadlines, study objectives and a summary of the findings (Annexure 8.1), and informed consent leaflets (Annexure 8.2) were e-mailed or personally provided to participants who indicated their willingness to respond.

The instrument consisted of biographical information (Annexure 8.3), the seven draft guidelines, as well as the actions for each guideline (Annexure 8.3). Participants were requested to rate each guideline and its actions with regards to the criteria of reliability, validity,

applicability, clarity and flexibility. The response choices were based on a four-point Likert-type scale to measure levels of agreement (Stitt-Gohdes & Crews, 2004: 63; Jones & Rattray, 2010: 376). Participants were asked for comments or suggestions at the end of each guideline. Fifteen participants rated the guidelines and no comments or suggestions were provided.

4.4.2.2 Data analysis

Responses from participants were screened, analysed and collated (Stitt-Gohdes & Crews, 2004: 62). The scores for each guideline as rated according to the four-point Likert scale were collated and presented in Table 4.3. Consensus was reached after the first round of the Delphi, see Table 4.4 for consensus rates.

Table 4.3 Rating of guidelines – Delphi round (n=15)

	Validity				**Reliability**				**Applicability**				**Clarity**				**Flexibility**			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
GUIDELINE 1			11	4			10	5			8	7			11	4			7	8
GUIDELINE 2			10	5			11	4			9	6			11	4			7	8
GUIDELINE 3			8	7			11	4			11	4			12	3			7	8
GUIDELINE 4			11	4			11	4			8	7			10	5			8	7
GUIDELINE 5			12	3			10	5			10	5			12	3			5	10
GUIDELINE 6			11	4			11	4			12	3			12	3			8	7
GUIDELINE 7			11	4			9	6			11	4			8	7			5	10
TOTAL			31	74			32	73			36	69			29	76			58	47

Table 4.4 Consensus rates – Delphi Round

	Validity				Reliability				Applicability				Clarity				Flexibility			
	1	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**
GUIDELINE 1			33	16			30	20			24	28			33	16			21	32
GUIDELINE 2			30	20			33	16			27	24			33	16			21	32
GUIDELINE 3			24	28			33	16			33	16			36	12			21	32
GUIDELINE 4			33	16			33	16			24	28			30	20			24	28
GUIDELINE 5			36	12			30	20			30	20			36	12			15	40
GUIDELINE 6			33	16			33	16			36	12			36	12			24	28
GUIDELINE 7			33	16			27	24			33	16			24	28			15	40
TOTAL			**222**	**124**			**219**	**128**			**207**	**144**			**228**	**116**			**141**	**232**
TOTAL (3+4)			**346**				**347**				**351**				**344**				**373**	
CONSENSUS RATES	**76%**				**77%**				**78%**				**75%**				**85%**			

4.5 FINAL GUIDELINES

This section gives a descriptive overview of the final guidelines.

GUIDELINES FOR NURSING MANAGEMENT TO ENSURE EFFECTIVE CARE TO MHCUs LIVING WITH HIV/AIDS
Purpose and objectives
The purpose of the guidelines is to ensure effective care to MHCUs living with HIV/AIDS.
The scope of the guidelines
The guidelines were developed for nursing management to ensure psychiatric nurses provide effective care to MHCUs living with HIV/AIDS. It is recommended that psychiatric nurses receive supervision from an advanced psychiatric nurse, skilled in psychiatric nursing, to facilitate the implementation of the guidelines. The facilitator will guide and supervise psychiatric nurses to take care of MHCUs living with HIV/AIDS as recommended in the guidelines.

Background
Nursing management in psychiatric hospitals face multifaceted challenges posed by the care provided to MHCUs living with HIV and AIDS. Challenges include factors such as stigma and discrimination against these MHCUs who may present with suicidal, self-harming, psychotic and aggressive behaviours. Nurses' responses to these MHCUs might be affected by their fear of aggression and contamination with body fluids. The institution may lack adequate resources to meet MHCUs' needs.
Development of the guidelines
Seven guidelines were developed by the researcher in accordance with and guided by the findings of a qualitative study to explore and describe the experiences of psychiatric nurses of providing care to MHCUs living with HIV and AIDS in a public psychiatric hospital in Gauteng; and a literature review (Chapter 3). The attributes that guided the researcher throughout the development process were derived and adapted from the AGREE II instrument (Brouwers *et al.*, 2010). The guiding attributes were rigour, flexibility, clarity and applicability, stakeholder involvement and scope and purpose.
Validation of the guidelines
The guidelines were validated with the help of a panel of experts. A Delphi technique was utilized to validate the guidelines. A panel of experts rated each of the seven guidelines and its actions with regard to the criteria of reliability, validity, applicability, clarity and flexibility. The response choices were based on a four-point Likert-type scale to measure levels of agreement. A consensus rate of 78% was obtained on the validity, reliability, flexibility and applicability of the guidelines.
Guidelines
Each guideline was stated followed by a rationale and specific actions to facilitate the actualisation of the guideline.
Potential resources, facilitators and barriers to guideline application
The facilitators to the application of the guidelines are human resources (advanced psychiatric nurses and skilled interdisciplinary mental health-care practitioners) employed at psychiatric hospitals in Gauteng. The researcher is prepared to disseminate the guidelines

through publications and workshop proceedings.
The barriers to application of the guidelines are foreseen as insufficient resources such as time and finances. The guideline implementation relies on the motivation of psychiatric nurses to implement change and the ability of management to formulate policies and ensure that the human, financial and managerial resources are made available to implement the guidelines. Effective training, ongoing supervision, teambuilding and debriefing should be made available to support psychiatric nurses providing care to MHCUs living with HIV and AIDS.
Review and updating of the guidelines
It is recommended that the guidelines be reviewed and updated after they have been implemented and tested in practice, and thereafter every three years.

4.6 CONCLUSION

In this chapter the development of guidelines to ensure effective care to MHCUs living with HIV/ AIDS were discussed. The guidelines were presented, followed by the methodology and results of the Delphi technique to validate the guidelines. A descriptive overview of the final guidelines was presented.

CHAPTER 5: CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

A qualitative, explorative, descriptive and contextual design and Delphi technique was used to meet the objectives of this study. The objectives were to explore and describe psychiatric nurses' experiences of providing care to MHCUs living with HIV and AIDS in a public psychiatric hospital in Gauteng, and to develop guidelines for nursing management based on psychiatric nurses' experiences to ensure effective care to MHCUs living with HIV and AIDS. An introduction and the statement of the problem were discussed in Chapter 1. A full description of the research methodology was done in Chapter 2 and individual interviews and field notes were recorded. Subsequently, obtained data were categorized and analysed. The findings were reported in Chapter 3. The guidelines were drafted and validated through a Delphi technique in Chapter 4. Representatives of the group targeted for the guidelines, namely psychiatric nurses, health-care professionals and other experts in the field of study were included. The guidelines were based on phase 1 of this study which represents the psychiatric nurses' experiences. Review of the guidelines was recommended after development. The process of developing guidelines, the evidence used, assumptions made, and participants involved were accurately documented and described.

5.2. CONCLUSION

Data from the interviewed transcripts were grouped into four main categories: experiences of fear caring for MHCUs living with HIV/AIDS, experiences of aggressive behaviour of MHCUs living with HIV/AIDS, experiences of difficulties in caring for MHCUs living with HIV/AIDS, and a need for support in caring for MHCUs living with HIV/AIDS. These were subdivided into subcategories.

The findings were gathered into four main clusters that logically belonged together (see Table 4.1). From cluster 1 two guidelines were derived, from cluster 2 two guidelines were also derived, from cluster 3 one guideline, and from cluster 4 two guidelines were developed. The guidelines were based on the findings, and on the appropriate literature. Each of the seven

guidelines was discussed in accordance with the rationale and certain actions recommended to implement the guideline. The guidelines were validated by a team of experts to ensure certain criteria for the development of effective guidelines were met. The guidelines can be used to address the current working environment in order to improve the quality of service delivery in psychiatric hospitals. This includes providing psychiatric nurses with opportunities to develop self-awareness with regards to the attitudes towards MHCUs living with HIV/AIDS, exposing nurses to regular debriefing to identify, express and develop ways to cope with emotional experiences related to care for MHCUs living with HIV/AIDS, and, finally for continuous professional development related to the provision of care to MHCUs living with HIV/AIDS. See summary of guidelines in Table 5.1.

Table 5.1: Summary of guidelines for nursing management to ensure effective care to MHCUs living with HIV and AIDS.

	GUIDELINES
GUIDELINE 1	Psychiatric nurses are provided with opportunities to develop self-awareness with regards to their attitudes towards MHCUs living with HIV/AIDS
GUIDELINE 2	Psychiatric nurses are exposed to regular debriefing to identify express and develop ways to cope with emotional experiences (specific references to fear) related to care for MHCUs living with HIV/AIDS**.**
GUIDELINE 3	Psychiatric nurses are capacitated to use therapeutic interventions to facilitate improved insight in MHCUs living with HIV/AIDS.
GUIDELINE 4	Psychiatric nurses receive managerial and interdisciplinary support in management of aggression in MHCUs living with HIV/AIDS.
GUIDELINE 5	Psychiatric nurses are provided with opportunities to reflect on and improve their ways of coping with the provision of care to MHCUs living with HIV/AIDS.
GUIDELINE 6	Psychiatric nurses are capacitated with continuous professional development related the provision of care to MHCUs living with HIV/AIDS.
GUIDELINE 7	Psychiatric nurses are encouraged to develop peer support structures related to the provision of care to MHCUs.

5.3. LIMITATIONS OF THE STUDY

The researcher identified the criteria for inclusion in the study, which was only professional nurses. The researcher is aware of other categories of health professions who were excluded from the study such is enrolled nurses, social workers, occupational therapists and support staff. These other categories could have come up with different perceptions regarding the current study. A medical officer was used in Delphi study as one of the experts in the field

The researcher is aware that the study was conducted in a psychiatric hospital where there are both male and female nurses, but only female professional nurses participated. The researcher is also aware that health professionals of all races were not included in the study, such as Indians and coloureds.

The research was conducted in only one psychiatric hospital in Gauteng. There is a need to further the research to other hospitals to compare the findings. It was very difficult to get enough participants for the study as some participants ignored the invitation and some withdrew from taking part. Some participants were not comfortable and were hesitant to share information.

5.4 RECOMMENDATIONS

Recommendations will be set for nursing practice, management and education as well as further research.

5.4.1 Recommendation for nursing practice

Recommendations to improve the standard of nursing care to MHCUs living with HIV/AIDS include the following:

- Psychiatric nurses providing care to MHCUs living with HIV/AIDS need to exercise a range of skills in order to provide quality of care.
- Psychiatric nurses should provide applicable health information and effective education to support the MHCUs living with HIV/AIDS, to promote compliance and improve the insight of MHCUs in their physical and psychological problems.

- Norms and cultural practices that are unfavourable, such as stigma, should be addressed so that the nursing practice can build and support the MHCUs and families to improve their quality of life.
- Psychiatric nurses providing care to MHCUs living with HIV/AIDS need to ensure that the environment in which they work supports safe and effective working practices and protects the MHCUs and their families.

5.4.2 Recommendations for nursing management

The management of the psychiatric hospital should grant psychiatric nurses opportunities to further their studies in advanced psychiatric nursing. This will improve and encourage evidence–based practice with regards to care of MHCUs living with HIV/AIDS in a psychiatric hospital.

- Management should ensure that there is a support system available in the hospital where psychiatric nurses with similar problems can meet and discuss their problems and challenges.
- Management should encourage psychiatric nurses to participate in community awareness campaigns to share information about MHCUs living with HIV/AIDS.
- Management should ensure that in-service training is done more effective by doing ongoing monitoring and evaluation of the outcome of the training and the training needs of the nurses.
- Management should ensure opportunities for debriefing of psychiatric nurses are available and enough resources are available to manage aggressive MHCUs.
- Management should ensure teambuilding opportunities are provided regularly for psychiatric nurses to support and assist one another as a team.
- Other interdisciplinary mental health-care providers should assist psychiatric nurses in the provision of care to MHCUs living with HIV/AIDS.
- Management should make opportunities available where psychiatric nurses can reflect on their practice and develop self-awareness.

5.4.3 Recommendations for nursing education

The training of psychiatric nurses should be integrated with the provision of physical care to MHCUs to allow all nurses to perform their duties effectively. The nursing curriculum should include caring of MHCUs living with HIV/AIDS. All psychiatric nurses should be trained in new

evidence-based practices and guidelines during their training. Continuous training should be done to update them while in service.

- The Ministry of Health and programme managers should assess the pre-service training curricula for all cadres of health-care providers to ensure that essential psychiatric care for MHCUs living with the HIV/AIDS component is included and should, therefore, be comprehensively incorporated in their curriculum.
- Psychiatric students should be provided with learning opportunities with regards to caring for MHCUs living with HIV/AIDS.
- Nurses need to be continuously updated and upgraded with latest programmes related to mental illness and HIV/AIDS. New research is being conducted, and treatment protocols change regularly.
- The in-service training on taking care of MHCUs living with HIV/AIDS must be a central priority of Ministry of Health's development system.
- Psychiatric nurses should also be empowered through training to deal effectively with handling of aggressive patients. Training can play an important role in overcoming some of the challenges faced by psychiatric nurses.
- Psychiatric nurses should also be empowered through training to practice using effective therapeutic skills to build therapeutic relationships with MHCUs and present therapeutic groups to improve the insight of MHCUs living with HIV/AIDS.
- Management of psychiatric hospitals must employ and utilize advanced psychiatric nurse practitioners in training, debriefing and supporting psychiatric nurses caring for MHCUs living with HIV/AIDS.

5.4.4 Recommendations for further research

A similar study can be conducted with a larger sample size in order to be able to use diverse demographic information when comparing the results. It is recommended that a probability sampling method should be used for future research with a view to collect results that are representative of the entire population.

Qualitative and quantitative research are needed in order to investigate and explore if the guidelines and recommendations proposed in this research would be effective in providing care to MHCUs living with HIV/AIDS in a psychiatric hospital. Possible research topics may include the development of a comprehensive training programme for psychiatric nurses

regarding caring of MHCUs living with HIV/AIDS.

5.5 CONCLUSION

In this chapter the conclusion was drawn, limitations were identified, and recommendations were formulated. It is concluded that the objectives of the study were achieved, based on the findings of the study, and the developed and validated guidelines. The findings suggest the need to increase quality psychiatric nursing care to MHCUs living with HIV/AIDS. Recruitment of advanced psychiatric nurses, retention strategies and in-service training should be enforced to reduce workload and improve the current psychiatric nursing-care services. The researcher has made recommendations to address the problem through implementing the guidelines. This report will be disseminated to all relevant bodies.

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ANNEXURE 1

PARTICIPANT'S INFORMATION & INFORMED CONSENT DOCUMENT

STUDY TITLE: Guidelines for psychiatric nurses taking care of mental health care users living with HIV and AIDS in a public psychiatric hospital

Principal Investigator: Ms MG Zulu

Institution: [redacted]

DAYTIME AND AFTER HOURS TELEPHONE NUMBER(S):

Daytime numbers: 0795472016, Afterhours: 0795472016

DATE AND TIME OF FIRST INFORMED CONSENT DISCUSSION:

dd	**mmm**	**y**

:
Time

Dear Participant

Dear Mr. / Mrs. .... date of consent procedure …...../…....../…......

1) INTRODUCTION

You are invited to volunteer for a research study. This information leaflet is to help you to decide if you would like to participate. Before you agree to take part in this study you should fully understand what is involved. If you have any questions, which are not fully explained in this leaflet, do not hesitate to ask the investigator. You should not agree to take part unless you are completely happy about all the procedures involved.

2) THE NATURE AND PURPOSE OF THIS STUDY

You are invited to take part in a research study. The aim of this study is to evaluate the

experiences of psychiatric nurses taking care of mental health care users living with HIV and AIDS in a public psychiatric hospital. By doing so we wish to learn more about the experiences of nurses.

3) EXPLANATION OF PROCEDURES TO BE FOLLOWED

This study involves answering some questions during an interview with the researcher with regard to experiences of psychiatric nurses taking care of mental health care users living with HIV and AIDS in a public psychiatric hospital.

4) RISK AND DISCOMFORT INVOLVED.

The only possible risk and discomfort involved is emotional discomfort during the interview. The researcher will assess any such discomfort and refer you to a counselor if required.

5) POSSIBLE BENEFITS OF THIS STUDY.

The will enable us to develop guidelines for psychiatric nurses taking care of mental health care users living with HIV and AIDS in a public psychiatric hospital.

6) I understand that if I do not want to participate in this study, I will not be disadvantaged in any way.

7) I may at any time withdraw from this study.

8) HAS THE STUDY RECEIVED ETHICAL APPROVAL?

This Protocol was submitted to the Faculty of Health Sciences Research Ethics Committee, University of Pretoria, telephone numbers 012 356 3084 / 012 356 3085 and written approval has been granted by that committee. The study has been structured in accordance with the Declaration of Helsinki (last update: October 2013), which deals with the recommendations guiding doctors in biomedical research involving human/subjects. A copy of the Declaration may be obtained from the investigator should you wish to review it.

9) INFORMATION If I have any questions concerning this study, I should contact:
Researcher: Ms MG Zulu: 0795472016. Supervisor: Dr AE van der Wath: 0845063142

10) CONFIDENTIALITY

All records obtained whilst in this study will be regarded as confidential. Results will be published or

presented in such a fashion that participants remain unidentifiable.

11) CONSENT TO PARTICIPATE IN THIS STUDY.

I have read or had read to me in a language that I understand the above information before signing this consent form. The content and meaning of this information have been explained to me. I have been given opportunity to ask questions and am satisfied that they have been answered satisfactorily. I understand that if I do not participate it will not alter my management in any way. I hereby volunteer to take part in this study.

I have received a signed copy of this informed consent agreement.

....

Participant name Date

....

Participant signature Date

....

Investigator's name Date

....

Investigator's signature Date

....

Witness name and signature Date

ANNEXURE 2

INTERVIEW GUIDE

Central questions to be asked during the individual unstructured interview:

What are your experiences of providing care to MHCUs living with HIV and AIDS in a psychiatric hospital in Gauteng?

Being exposed to HIV while working with MHCUs in a psychiatric hospital, how does it affect you as a person and your performance at work?

Examples of probing questions:

Tell me more about your experiences……
Please clarify/ explain the following……
Can you elaborate on……

Paraphrasing and reflection will be used to indicate interest and encourage participants to elaborate.

ANNEXURE 3
ETHICAL APPROVAL

The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.
- FWA 00002567, Approved dd 22 May 2002 and Expires 20 Oct 2016.
- IRB 0000 2235 IORG0001762 Approved dd 13/04/2011 and Expires 13/04/2014.

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

25/10/2013

Approval Certificate
New Application

Ethics Reference No.: 401/2013

Title: Psychiatric nurses' experiences of taking care of mental health care users living with HIV and AIDS in a public psychiatric hospital in Gauteng

Dear Ms Mamma Gladys Zulu

The **New Application** as supported by documents specified in your cover letter for your research received on the 25/09/2013, was approved by the Faculty of Health Sciences Research Ethics Committee on the 23/10/2013.

Please note the following about your ethics approval:
- Ethics Approval is valid for 2 years.
- Please remember to use your protocol number (**401/2013**) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, or monitor the conduct of your research.

Ethics approval is subject to the following:
- The ethics approval is conditional on the receipt of 6 monthly written Progress Reports, and
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

DR R SOMMERS; MBChB; MMed(Int); MPharmMed.
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee
University of Pretoria

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

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✉ Private Bag X323, Arcadia, 0007 - 31 Bophelo Road, HW Snyman South Building, Level 2, Room 2.33, Gezina, Pretoria

The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.
- FWA 00002567, Approved dd 22 May 2002 and Expires 03/20/2022.
- IRB 0000 2235 IORG0001762 Approved dd 22/04/2014 and Expires 03/14/2020.

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

28/06/2018

Approval Certificate
Amendment
(to be read in conjunction with the main approval certificate)

Ethics Reference No: 401/2013

Title: Guidelines for psychiatric nurses taking care of mental health care users living with HIV and AIDS in a public psychiatric hospital

Dear Mrs Mamma Gladys Zulu

The **Amendment** as described in your documents specified in your cover letter dated 25/06/2018 received on 25/06/2018 was approved by the Faculty of Health Sciences Research Ethics Committee on its quorate meeting of 27/06/2018.

Please note the following about your ethics amendment:
- Please remember to use your protocol number (**401/2013**) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committe may ask further questions, seek additional information, require further modification, or monitor the conduct of your research.

Ethics amendment is subject to the following:
- The ethics approval is conditional on the receipt of 6 monthly written Progress Reports, and
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

Dr R Sommers; MBChB; MMed (Int); MPharMed; PhD
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes, Second Edition 2015 (Department of Health).

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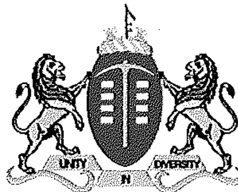
ANNEXURE 4
INSTITUTIONAL APPROVAL



GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Enquiries : Mrs M A Mabena
Tel : (012) 319 9800
Fax : (012) 3277076
E-mail : Maureen.Mabena@gauteng.gov.za

PERMISSION TO CONDUCT RESEARCH AT WESKOPPIES HOSPITAL

Dear Ms Zulu

Permission to conduct research study at this hospital on the topic **"Psychiatric nurse's experiences of providing care to MHCUS living with HIV and AIDS in a public psychiatric hospital in Gauteng"** is provisionally granted pending the approval by the Ethics Committee of the Faculty of Health Sciences of the University of Pretoria

....

Mrs M A Mabena
Chief Executive Officer
Weskoppies Hospital
16 September 2013.

ANNEXURE 5
TRANSCRIBED INTERVIEW

Patient –Participant's interview

R: Good afternoon.

P: Good afternoon.

R: Tell more about yourself?

I'm a professional nurse. Infact I started my nursing career 1992 as an enrolled nurse and done bridging course and later done my BCUR at North West university which I completed in 2013 march. So right now I'm a professional nurse.

R: How long have you working in this place?

P: 11 years

R: During your stay here did you ever nurse a MHCUS whose being diagnosed with HIV/AIDS and if so how often?

P: Yes

P: We meet them on daily basis

R: How do you feel about it?

P:I feel bad and sad because this patients they don't have insight about their conditions, so it makes our lives and theirs live at risk or my life as a nurse at risk .because is like they don't know the dangers and risk of this condition .

R: I hear that they don't have insight about their mental status?

P: Because they put other pupils life at risk when they fight they like to bite, which is very dangerous thing they can infect you or other users. Even taking of medication they think is not important cause they know the drugs that they normal use so they don't see the important of taking other medication .it makes life difficult to all of and family of users. Even if the y bleed the don't care they can spray the disease easy and carelessly reason being they rely understand their medical condition recklessly. Majority is non compliance related to what I just said. Other s psychosis due to HIV dementia maturity is noncompliance to above mention

R: Can you please elaborate on that?

P:Is like they will take their medication for certain period and when they relapse they stop taking medication and in the process they develop resistance to the treatment

R: Do u think are things that nurses can do to improve on that?

P:Yes Main important think to keep on educating users about disease its self set down teach important of taking medication abstain from fighting another, unnecessary fighting and biting other also to educate the family cause they are the too spent time with the users . To educate family to be more supportive to the users

To give health education about the medication

Intervene when patient is better about compliance. and to continue educating the whole family

R: Hear u said behavior may harm family, patient and nurses, can u tell more about it?

P: Starting from family everything start at home like refusing taking medication fighting, how to handle blood to pt next to him must being exposed unnecessary to the sickness

R: ok about nursing personnel?

P: Main important for example giving of medication

Psychotic or not make sure environment should be safe to such extent other pt when they see you are alone he can retract the need and inject you or just disturb you so as to inject yourself is important to assess mental or ask for manpower to assessed cause most of incident happen during giving of medication. While they see you are alone If they see u are alone thy can disturb u as to injure yourself

R: And how does it leave u?

P:It leaves me in fear, even if is not needle prick, most cases is human bite and stress of going through prophylactic procedure, test and all these, even you know users is positive is very dangers u don't if u don't know is the user is going to fight you

R: Does management does much to help or to support you?

P: Nothing much, they will tell you of safety measure if incident happen they will start questioning you. Will take patient site, they will instant question the nurse why she did what she did is like when they intervene is as if the nurse is wrong

R: What do you think should be done to help?

P:There is Nothing much as i can say other users u can predict, other just relapse immediate u discover later that it was sign of relapse be done because you cannot predict what is going to happen next . The only thing that can be done is too practice safety measure all the times, for instance keep your distance you don't go next to him or her when inject not be alone

R: From your experience do you think there is a gap in training psychiatric nurses?

P: Yes training is needed and more focus on handling of aggressive users and techniques to use, tactics nurses need to be exposes to continuous training. At least to know what expect and how to fight back or how to protect yourself like it happen to hijack u

R:Did u ever exposed to the situation whereby patient are fighting each other and chances of being exposed to the risk was high and if yes what is it. ?

P:Yes two users were fighting one staff get between them and was beating on the right arm when intervening and the user was HIV positive what notice u find that users fighting where u c if not intervene one is going to die when intervene and user can be angry and come back to you. It happen and I saw it and the user was positive is it was bad for nurses to take staff to those procedures

R: How does it make you feel?

P: Sad and bad and feel as if you can just leave psychiatric nursing in terms of exposing yourself from unnecessary diseases like just leave to a place where one will not be exposed to such risk

R: Do you get support from unit manager?

P: The support from the unit managers really it will depend but are just like management. they will blame you as being u did approach users properly or you were didn't have time for the users, like you will be an

end product of being blamed nothing much you will get although while coming to counseling before getting prophylactics or if taken to life crisis where you will get word of encouragement .

R: If you have to do something to reduce the risk what can you do?

P:I have given an example of two patients fighting in such situations ,I think most important thing is just not get inside to, first question they are going to ask is what were u doing avoid getting involve, avoid to be a hero. Just wait and if is safe to intervene then intervene. Or scream at them till they leave one another Let's say you are going to inject patient ask for help at least two to three nurses to come help, make sure your safe, to be safe not to be alone when doing those procedure alone

R: I hear you what if management challenges you that you didn't intervene?

P: Ys it so we can know what to I don't think u can be challenged why did stop them while fighting. what if you don't know how to intervene. At times your safety comes first you can intervene while they are both calm

R: If you neglect the patient fighting will they not blame you?

P:Yes management but if you can mention thy way the fighting's and you could see will be the next victim you can challenge that your safety come first ,patients are there for us but we need to be safe too, u cant expose yourself to unnecessary infection because you trying to make users not fight we know we are in psychiatric hospital they can blame you but if u mention the way the situation was they will understand, we know in a psychiatric hospital patient fights on continuous bases they can fight for cigarette when you turn they will fight for the matches. Don't expose yourself for sake of management

R: it sound like working environment is very stressful?

P: Very stressful and support is not much and there are no session to help us to ventilate our feelings. Like those things are missing out even if incident is being reported everyday

R: And that you are not getting much support from management?

P: Yes we are not

R: How do you feel about it?

R: Like not getting much support from management

R: How does it affect you at home?

P: The problem is when you knock off being exposed to such situation they haunt you while at home. You know you must wake up going back to the same situation like facing patients maybe who beat u Sometimes it contribute to a person not going to work. It can affect you mentally, emotionally and physically

R: Does it affect your daily functioning?

P: It does but those patients there is nothing u can do,

There is nothing more u can do even if she split saliva on you and these day because of their mental health status and majority the know their rights, others that I will head u and I will not appear in court

R: Hear about talking about rights?

P: It makes you realized as if patients know more about their right if and if u exercises your rights like you are neglecting them. Due to your mental status your rights are going to be compromise

It makes u realize thy know much about their rights

R: And how does it leave u as a nurse?

P: Very frustrated not knowing exactly what to do cause if you allow him not to take medication he is going to relapse.

R: Tell your experience of working with HIV patient for ten years?

P: What I discovered is that majority of them they know their medication's. I think there are two site of the story here there are those who know their medication they can even teach you what they have being taught at the clinic and there are those who are psychotic they can go to the extent of even splitting the medication which in turn will lead them to resistance and non compliance

R: What had you learn so far?

P:Majority of them can utilize as an anger like I'm going to do this and that to a nurse or they can initiate a fight as to bite you intentional or spit saliva on you realize they do it purposefully ,they can tell you I m going to bite your finger and this is going to infect you very few patients will do the act out of innocent, we had a users who said to nurse I'm going to bite your finger and you will go to crisis center in Laudium hospital

Some patients are very manipulative; they can do things with intention to infect others. It does not happen every day but it does happen

R: So they are good and bad sight about It.?

P: I discovered that there no safe place. Like now patient start as 72 hour before being admitted. I think this is a world recognized risk, it doesn't matter whether you are working in general hospital or World

R: How does it affect you as a person?

P:As a person for the years I have worked with mental ill patients I have learn mental illness a lot like for instant one need to have patient, understanding and one need to respect others.

R: Specifically how does it affect you?

P:I think I learn to realize and except the situation. It taught me about respect. Not to be non judgmental.

R: How does it affect your performance?

P: Regardless of everything I still like psychiatric nursing, is not difficult you just need to have skill and it makes me to be strong person.

R: Do you think one need to have certain experience to work there?

P: Yes experience is need and qualification to support yr experience. They both work together. If your new others experienced nurses will help. We work as a team

R: ok based on that currently there are high rate of resignations how does this affect your workload?

P: I think what is important is to balance the staff, for example in acute ward

R: Can you please elaborate on working as a team?

P: I mean like when you do things we do together when we discus about the patient you do as team and with consistent.

R: I hear you talked about training, experience and team work?

P: Training that where you get theory experience challenges that you get every day, what I will like to say is that experienced people function better than a new people

R: Did you ever find yourself whereby situation got out of control?

P: Yes like we once had an incident where by the patient has history of human bites and it was not safe for other patients and for the nurses to the multi team concluded that teeth has to be removed. The user has to go to Steve Biko to remove the teeth; it was done and was no complaint

R: How does it leave you as personnel?

P:Bad and fear cause was using it as a weapon, so the patient was getting away with everything to avoid being next victim when you see he want to quarrel one will just keep quiet to avoid the situation, make sure your safe. Sometimes it happens that the users do not like you. In some instances the user just hates you, in that instances they may change you to another ward for your own safety.

R: How does it make you feel?

P: Normally I don't take it personal due to the manner of the condition.

R: You said you are not affected by their behavior?

P: Even swearing, anything they say

R: What are you e trying to say?

P:I m saying because I understand their condition is better to be swearing at by users than a patient with asthma at a general hospital .about infection yes is going to be bad is going to affect. But also you can be still being infected even in general hospital. All I'm saying is risk of being infected is the same whether you are in psychiatric or general hospital.

R: ok I hear you talked about the risk how you think can be done to reduce the risk?

P: Really is like saying general rules like recap needle work as a team, as well as manpower

In short what can be done to help to reduce or prevent nurses being exposed to the risk?

Continues training, workshops

More awareness, training

R: ok and from management?

P: Most important role to be supporting, debriefing session to voice out anger and frustration

R: ok and from patient site as well?

P: Understand their mental status and also family to be involved. To provide support system

R: thank so much for your time

ANNEXURE 6
CODING CERTIFICATE

Qualitative Data Analysis

MCur in Psychiatric Nursing

Gladys Zulu

THIS IS TO CERTIFY THAT

Dr. Annie Temane has co-coded the following qualitative data:

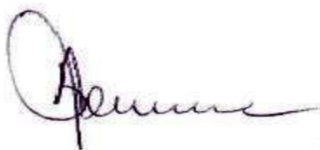
8 Individual Qualitative Interviews

For the study:

PSYCHIATRIC NURSES' EXPERIENCES OF TAKING CARE OF MENTAL HEALTH CARE USERS LIVING WITH HIV/AIDS IN A PUBLIC PSYCHIATRIC HOSPITAL IN GAUTENG

I declare that the candidate and I have reached consensus on the major themes, categories and codes reflected by the data during a consensus discussion. I further declare that adequate data saturation was achieved as evidenced by repeating themes.

Annie Temane



M.A.Temane (D.Cur; Research Methodology)

annie.temane@gmail.com

ANNEXURE 7
EDITING CERTIFICATE

I, *Annelize Dorfling*, language practitioner and linguist,

hereby solemnly state that I have edited

Guidelines for psychiatric nurses taking care of mental health-care users living with HIV and AIDS in a public psychiatric hospital

by

Ms. Gladys Zulu

Dissertation for the M Cur dissertation

at the
Department of Nursing Science

at the
University of Pretoria

Name of editor: Ms Annelize Dorfling

Signature:

Contact number: 082-371-5753

Email address: annelize.dorfling@gmail.com

Date issued: 13 May 2019

ANNEXURE 8

8.1 COVER LETTER - DELPHI

Date

Dear ……..

Development of guidelines for psychiatric nurses taking care of mental health care users living with HIV and AIDS in a public psychiatric hospital

You are hereby invited to participate in the validation of guidelines using a Delphi technique. It is expected that not more than two rounds of the Delphi will be sufficient to obtain consensus on the content of the guidelines. The aim of the research and summary of findings are provided on page 2.

There are seven guidelines. Please read through each guideline and complete the rating scale in accordance with the criteria which include: validity, reliability, flexibility, clarity and applicability of the guideline. If applicable, please provide suggestions for re-formulation of the guideline in the space for comments. Please complete the biographical information in the first section of the instrument by providing descriptive information on your professional and academic experience. This will enable the researcher to describe the sample. No names or identities will be mentioned in the research report or publications. The validation process should take approximately 30 minutes to complete.

Your participation and comments will be highly appreciated. Comments received will be collated and analysed for further validation in round two. Attached is a consent form that should be returned with the comments should you agree to participate in the study. For any clarification that may be required please contact me or my supervisor on the following:

Principal Investigator:
Gladys Zulu
Tel: 0795472016

Supervisor:
Annatjie van der Wath
E-mail: annatjie.vanderwath@up.ac.za
Tel: +27 (0)12 3542274
Cell: +27 (0)84 506 3142

Aim of the research

The aim of the research was to explore psychiatric nurses' experiences of providing care to MHCUs living with HIV/AIDS in a psychiatric hospital. The first objective was to explore and describe psychiatric nurse experiences of providing care to MHCUs living with HIV/AIDS in a public psychiatric hospital. The second objective of the research was to develop guidelines based on psychiatric nurses' experiences. The guidelines were developed for management to ensure effective care to MHCUs living with HIV and AIDS.

The draft guidelines were developed by the researcher guided by the findings and literature review.

Summary of main findings

Data from the interview transcripts were grouped into four main categories: experiences of fear caring for MHCUs living with HIV/AIDS, experiences of aggressive behaviour of MHCUs living with HIV/AIDS, experiences of difficulties in caring for MHCUs living with HIV/AIDS and a need for support in caring for MHCUs living with HIV/AIDS. These were subdivided into subcategories.

Participants experienced emotional turmoil characterized by feelings of frustration, fear, confusion and anger. They indicated that they are not able to do their work to their best ability because they are afraid they might be infected while busy providing care to MHCUs. The participants did not feel free to intervene with these MHCUs because they think some of the MHCUs have intentions of infect them. They indicated that MHCUs often behave in violent ways, sometimes for no apparent reason. In the process the nurses might get hurt trying to calm them down or trying to stop the conflict.

The findings also indicated that the MHCUs seemed not to understand much about their illness and treatment, hence they sometimes refuse to take medication as prescribed. The MHCUs displayed a lack of insight into their psychiatric problems, but also with regards to the HIV diagnosis resulting in a lack of compliance with their treatment regimens. Participants also verbalized that they sometimes feel like resigning from their work place due to the high risk behaviour they are facing.

Participants revealed that they often feel negative towards MHCUs living with HIV/AIDS and avoid working with them, especially if they know that the MHCU has aggressive tendencies.

The psychiatric nurses in the study expressed a need for ongoing training in handling of aggressive MHCUs, so as to improve the outcomes. There is a need to remove stigma in mental health and HIV by educating nurses. There is also a need to provide support to psychiatric nurses by addressing their issues and improving their work conditions. Psychiatric nurses also need teamwork from the multidisciplinary team to assist them with management of MHCUs.

8.2 PARTICIPANT'S INFORMATION & INFORMED CONSENT DOCUMENT - DELPHI

STUDY TITLE: Development of guidelines for psychiatric nurses taking care of mental health care users living with HIV and AIDS in a public psychiatric hospital

Principal Investigator: Ms MG Zulu
DAYTIME AND AFTER HOURS TELEPHONE NUMBER(S):
Daytime numbers: 0795472016, Afterhours: 0795472016

DATE AND TIME OF FIRST INFORMED CONSENT DISCUSSION:

				:
dd	**mmm**	**ivy**		**Time**

Dear Participant

Dear Mr. / Mrs. .... date of consent procedure …....../…......./….......

1) INTRODUCTION

You are invited to volunteer for a research study. This information leaflet is to help you to decide if you would like to participate. Before you agree to take part in this study you should fully understand what is involved. If you have any questions, which are not fully explained in this leaflet, do not hesitate to ask the investigator. You should not agree to take part unless you are completely happy about all the procedures involved.

2) THE NATURE AND PURPOSE OF THIS STUDY

You are invited to take part in a research study. The aim of this study is to develop and refine guidelines for psychiatric nurses taking care of mental health care users living with HIV and AIDS in a public psychiatric hospital. By doing so we wish to enable management to support the nurses in a more effective way.

3) EXPLANATION OF PROCEDURES TO BE FOLLOWED

This study involves reviewing the draft guidelines proposed by the researcher in two rounds. During the first round you will be required to complete a rating scale with regard to the validity and reliability of the guidelines for psychiatric nurses taking care of mental health care users living with HIV and AIDS in a public psychiatric hospital. You will also be requested to make recommendations to improve the guidelines. During the second round the revised guidelines will be send back to you and you will have another opportunity to review the guidelines and make more recommendations if you wish to do so.

4) RISK AND DISCOMFORT INVOLVED.

The only possible risk and discomfort involved is the time it will take to review the guidelines, which will not take longer than 90 minutes of your time.

5) POSSIBLE BENEFITS OF THIS STUDY.

This will enable us to refine the guidelines for psychiatric nurses taking care of mental health care users living with HIV and AIDS in a public psychiatric hospital.

6) I understand that if I do not want to participate in this study, I will not be disadvantaged in any way.

7) I may at any time withdraw from this study.

8) HAS THE STUDY RECEIVED ETHICAL APPROVAL?

This Protocol was submitted to the Faculty of Health Sciences Research Ethics Committee, University of Pretoria, telephone numbers 012 356 3084 / 012 356 3085 and written approval has been granted by that committee. The study has been structured in accordance with the Declaration of Helsinki (last update: October 2013), which deals with the recommendations guiding doctors in biomedical research involving human/subjects. A copy of the Declaration may be obtained from the investigator should you wish to review it.

9) INFORMATION

f I have any questions concerning this study, I should contact:
Researcher: Ms MG Zulu: 0795472016, Supervisor: Dr AE van der Wath: 0845063142

10) CONFIDENTIALITY

All records obtained whilst in this study will be regarded as confidential. Results will be published or presented in such a fashion that participants remain unidentifiable.

11) CONSENT TO PARTICIPATE IN THIS STUDY.

I have read or had read to me in a language that I understand the above information before signing this consent form. The content and meaning of this information have been explained to me. I have been given opportunity to ask questions and am satisfied that they have been answered satisfactorily. I understand that if I do not participate it will not alter my management in any way. I hereby volunteer to take part in this study.

I have received a signed copy of this informed consent agreement.

....	....
Participant name	Date
....	....
Participant signature	Date
....	....
Investigator's name	Date
....	....
Investigator's signature	Date
....	....
Witness name and signature	Date

8.3 DELPHI QUESTIONNAIRE

Professional qualifications		Experience in the field of HIV/AIDS	
		Specify and elaborate on experience for example:	
		Teaching	
		Practical experience	
Occupation		Research	
		Publications	
Employer			
Professional experience		**Experience in the field of mental health**	
		Specify and elaborate on experience for example:	
		Teaching	
		Practical experience	
		Research	
		Publications	

DELPHI INSTRUMENT																				
Please read through the guideline and actions and complete the rating scale in accordance with the criteria as described.																				
	Criteria																			
Rating scale guide: *4 = Strongly agree* *3 = Agree* *2 = Disagree* *1 = Strongly disagree*	**Validity:** Guideline will facilitate effective care to MHCUs living with HIV and AIDS				**Reliability:** Given the same circumstances psychiatric nurses would interpret and apply the guideline similarly				**Applicability:** Target population is clearly stated: Psychiatric nurses caring for MHCUs living with HIV and AIDS				**Clarity:** Guideline is precise, unambigious, user-frienly and logic				**Flexibility:** Guideline will empower psychiatric nurses caring for MHCUs living with HIV and AIDS to implement changes as applicable and re-evaluate their practice			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
GUIDELINE 1: Psychiatric nurses are provided with opportunities to develop self-awareness with regards to their attitudes towards MHCUs living with HIV/AIDS.																				
GUIDELINE 2: Psychiatric nurses are exposed to regular debriefing to identify, express and develop ways to cope with emotional experiences (specific references to fear) related to care for MHCUs living with HIV/AIDS																				
GUIDELINE 3: Psychiatric nurses are capacitated to use therapeutic interventions to facilitate improved insight in MHCUs living with HIV/AIDS.																				
GUIDELINE 4: Psychiatric nurses receive managerial and interdisciplinary support in management (prevention, de-escalation, intervention) of aggression in MHCUs living with HIV/AIDS.																				
GUIDELINE 5: Psychiatric nurses are provided with opportunities to reflect on and improve their ways of coping with the provision of care to MHCUs living with HIV/AIDS.																				
GUIDELINE 6: Psychiatric nurses are capacitated with continuous professional development related the provision of care to MHCUs living with HIV/AIDS.																				
GUIDELINE 7: Psychiatric nurses are encouraged to develop peer support structures related the provision of care to MHCHs living with HIV/AIDS																				