AN APPRECIATIVE INQUIRY OF PSYCHIATRIC NURSES' EXPERIENCE OF WORKPLACE SUPPORT IN A PRIVATE MENTAL HEALTH CARE SETTING

By

MRS M.C.I. SWART
87094322

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DEPARTMENT OF NURSING SCIENCE
UNIVERSITY OF PRETORIA

SUPERVISOR: DR. E.S. JANSE VAN RENSBURG

CO-SUPERVISOR: DR. R.G. VISAGIE

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DECLARATION

DECLARATION

This serves to confirm that I, Maria, Catharina, Isabelle, Swart (6809200033080), declare that the research, *An Appreciative Inquiry of Psychiatric Nurses' Experience of Workplace Support in a Private Mental Health Care Setting*, is my own work and has not been submitted for a degree or an examination at any other university. I further declare that all sources used and quoted in this research has been acknowledged and reflected in the reference list.

Signed at Pretoria on this 30 day of May 2011.

M.C.I. Swart

DEDICATION

To my Father

You have always given me everything in abundance.

Thank you

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I would like to take this opportunity to extend my sincere appreciation to the following people for supporting me during this research process:

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SUMMARY

Workforce shortages are a major concern of health care and the creation of a positive workplace is central to the attraction and retaining of employees where employees are motivated to be loyal towards their employer by a positive work experience rather than by financial rewards (Manion, 2009:XIII). This positive work experience can include the providing of workplace support that is tailored to the specific experiences and wishes of psychiatric nurses working at a private mental health care setting. Work demands encountered by psychiatric nurses can vary from personal stresses related to the interpersonal nature of working with the challenging behaviour of mental health care users, to environmental stresses related to an environment reflecting inadequate workplace support.

Stuart and Laraia (2005:11) described the role of the psychiatric nurse in any mental health care setting as depending on certain factors in the organisation. This include the philosophy, goals, prevailing understanding of mental health, the needs of the mental health care users, number of available personnel, communication structure, understanding of their individual roles, available resources and the presence of effective nurse mentoring.

As a professional psychiatric nurse, I identified the need for effective workplace support to psychiatric nurses working in a private mental health care setting by observing signs of burnout in psychiatric nurses and by listening to employees verbalising their need for workplace support.

The purpose of the research was to conduct an Appreciative Inquiry in order to generate an in-depth understanding of the experiences and wishes of psychiatric nurses regarding workplace support in a private mental health care setting. The objectives of the research were to explore and describe the experiences of psychiatric nurses regarding workplace support, to explore and describe the wishes of psychiatric nurses regarding workplace support in a private mental health care setting and to propose recommendations regarding workplace support. Proposed recommendations will have reference to psychiatric nursing research, psychiatric nursing education, psychiatric nursing management and psychiatric nursing practice, in order to facilitate more effective means to provide workplace support and to facilitate the promotion of the mental health of psychiatric nurses.

I decided to use an Appreciative Inquiry framework in order to explore the experiences and wishes of psychiatric nurses regarding workplace support. The importance of Appreciative Inquiry lies in the appreciation of the behaviour and the responses of individuals instead of focusing on their problems. Appreciative Inquiry identifies that which is positive in any system and connects to or builds on it in order to "heighten energy, vision and action for change" (Cooperrider, Whitney & Stavros, 2008:XV).

The meta-theoretical perspective that guided this researcher was the Theory for Health Promotion in Nursing. The essential purpose of this theory is health promotion for an individual, group, family or community (University of Johannesburg, 2009:4). The individual is in interaction with the environment, which consists of an internal and external environment. The internal environment comprises the body, mind and spirit dimensions of the individual. The external environment comprises the physical, social and spiritual dimensions of the individual. The interactions of these dimensions in the environment of the individual influence the health status of the individual on a continuum (University of Johannesburg, 2009:5). The experiences and wishes regarding the providing of workplace support pertaining to the internal and external environments of the psychiatric nurse were examined in order to facilitate the promotion of the mental health of the psychiatric nurse.

The theoretical and methodological perspective that guided this research was Appreciative Inquiry. Appreciative Inquiry uses a process known as the 4-D cycle, which is the process that is employed to facilitate change or to generate the power of Appreciative Inquiry (Whitney & Trosten-Bloom, 2003:6). For this research on workplace support, I employed the first two phases of Appreciative Inquiry, namely the discovery phase and the dream phase as part of the data collection. The discovery phase involves the appreciation or discovering of that which is positive, life giving or effective and the dream phase involves the imagining of new possibilities.

As a unique paradigm, Appreciative Inquiry questions traditional approaches to problem solving by accepting organisational challenges using an affirmative approach. An affirmative approach includes an appreciation of the positive by focussing on successes, strengths and potential (Cooperrider, Whitney & Stavros, 2008:433). Appreciative Inquiry views organisations as an individual centre of immense imagination and possibilities, intended to function as solutions (Cooperrider, Whitney & Stavros, 2008:16-17).

I used a qualitative design, which was exploratory, descriptive and contextual. I integrated an Appreciative Inquiry approach into this design.

I used purposeful sampling, which Polit and Beck (2007:763) define as a sampling method where participants are selected based on who will be the most informative regarding the topic of the research, namely workplace support in this research. The data collection methods used was naïve sketches, small core group inquiries and individual interviews with members of nursing management. The small core group inquiries included written answers on the interview schedule from the one-on-one interviews, transcribed feedback from the discussion phase, the positive core map, the nominal group technique, field notes and reflective interviews. The small core group inquiries were structured around one-on-one interviews that participants conducted with each other in groups of two, using an interview schedule. During the data analysis phase, I used two different techniques in order to analyse the available data, namely the nominal group technique and open coding.

I used a tree as symbol for workplace support at this mental health care setting. The roots of the tree symbolised the willingness of management to provide workplace support to their employees. The trunk of the tree symbolised the holistic approach to workplace support. The branches of the tree symbolised the identified themes. I represented the discovery phase categories as the green leaves of the tree. I represented the dream phase categories as pink buds.

I proposed recommendations relating to psychiatric nursing research, psychiatric nursing education, psychiatric nursing management and psychiatric nursing practice. The aim of these recommendations was to facilitate more effective means of providing workplace support, from a holistic perspective, in order to facilitate the promotion of mental health of psychiatric nurses working at this mental health care setting.

OPSOMMING

Tekorte in die arbeidsmag is 'n bron van groot besorgdheid vir gesondheidsorg, en die skep van 'n positiewe werkplek is sentraal tot die aantrekking en behoud van werknemers in gevalle waar werknemers deur middel van 'n positiewe werkservaring, eerder as 'n finansiële vergoeding, gemotiveer word om lojaal teenoor hul werkgewer te wees (Manion, 2009:XIII). Hierdie positiewe werkservaring kan die verskaffing van werkplekondersteuning, wat op die spesifieke ervarings en wense van psigiatriese verpleegspraktisyns wat in 'n privaat geestesgesondheidsomgewing werk, geskoei is, insluit. Werkseise wat psigiatriese verpleegspraktisyns teëkom kan wissel van persoonlike stres verwant aan die interpersoonlike aard van om met die uitdagende gedrag van geestesgesondheidsgebruikers te werk, tot omgewingstres verwant aan 'n omgewing wat ontoereikende werkplekondersteuning bied.

Stuart en Laraia (2005:11) beskryf die rol van 'n psigiatriese verpleegspraktisyn in enige geestesgesondheidsomgewing as afhanklik van sekere faktore in die organisasie. Dit sluit die filosofie, doelwitte, heersende begrip van geestesgesondheid, die behoeftes van die geestesgesondheidsgebruikers, die aantal beskikbare personeel, die kommunikasiestruktuur, begrip vir die individuele rolle, beskikbare hulpbronne en die teenwoordigheid van effektiewe verpleegsbegeleiding in.

As 'n professionele psigiatriese verpleegspraktisyn het ek die behoefte aan effektiewe werkplekondersteuning vir psigiatriese verpleegspraktisyns wat in 'n privaat geestesgesondheidsomgewing werk, waargeneem toe ek na tekens van uitbranding by die psigiatriese verpleegspraktisyns opgelet het, en na die werknemers geluister het wanneer hulle hul behoefte aan werkplekondersteuning verwoord het.

Die doel van hierdie studie was om 'n Waarderende Ondersoek te loods ten einde 'n indiepte begrip van die ondervindings en wense van psigiatriese verpleegspraktisyns met betrekking tot werkplekondersteuning in 'n privaat geestesgesondheidsomgewing te bewerkstellig. Die doelstellings van die studie was om die ondervindings van psigiatriese verpleegspraktisyns met betrekking tot werkplekondersteuning te beskryf ten einde die wense van psigiatriese verpleegspraktisyns met betrekking tot werkplekondersteuning in 'n privaat geestesgesondheidsomgewing te ondersoek en te beskryf en om aanbevelings te maak met betrekking tot werkplekondersteuning. Voorgestelde aanbevelings verwys na psigiatriese verpleegsnavorsing, psigiatriese verpleegsopleiding, psigiatriese

verpleegs-bestuur en psigiatriese verpleegspraktyk, om meer effektiewe metodes te fasiliteer ten einde werkplekondersteuning te voorsien en die geestesgesondheid van psigiatriese verpleegspraktisyns te bevorder.

Ek het besluit om 'n Waarderende Ondersoekraamwerk te gebruik te einde die ervarings en wense van psigiatriese verpleegspraktisyns met betrekking tot werkplekondersteuning te ondersoek. Die belangrikheid van 'n Waarderende Ondersoek lê in die waardering van die gedrag en terugvoer van individue, in plaas van om op hul probleme te fokus. Waarderende Ondersoek identifiseer dit wat positief is in enige stelsel en sluit daarby aan of bou daarop om energie, visie en aksie vir verandering te verhoog (Cooperrider, Whitney & Stavros, 2008:XV).

Die meta-teoretiese perspektief wat die navorser gelei het, was die Teorie vir Gesondheidsbevordering in Verpleging. Die hoofdoel van hierdie teorie is die gesondheidsbevordering van 'n individu, groep, gesin of gemeenskap (Universiteit van Johannesburg, 2009:4). Die individu is in interaksie met die omgewing, wat uit 'n interne en eksterne omgewing bestaan. Die interne omgewing sluit die liggaamlike, verstandelike en geestelike dimensies van die individu in. Die eksterne omgewing sluit die fisiese, sosiale en geestelike dimensies van die individu in. Die interaksies van hierdie dimensies in 'n individu se omgewing beïnvloed die gesondheidstoestand van die individu op 'n kontinuum (Universiteit van Johannesburg, 2009:5). Die ervarings en wense met betrekking tot die voorsiening van werkplekondersteuning wat met die interne en eksterne omgewings van die psigiatriese verpleegpraktisyn verband hou, is ondersoek ten einde die bevordering van die geestesgesondheid van die psigiatriese verpleegpraktisyn te fasiliteer.

Die teoretiese en metodologiese perspektief wat hierdie studie gelei het, was Waarderende Ondersoek. Waarderende Ondersoek gebruik 'n proses wat as die 4-D siklus bekend staan. Hierdie proses word gebruik om verandering te fasiliteer of om die krag van Waarderende Ondersoek te verseker (Whitney & Trosten-Bloom, 2003:6). Vir hierdie navorsing oor werkplekondersteuning het ek die eerste twee fases van Waarderende Ondersoek, naamlik die ontdekkingsfase en die droomfase, as deel van dataversameling gebruik. Die ontdekkingsfase sluit die waardering of ontdekking van wat positief, lewegewend of effektief is, in, en die droomfase sluit die verbeelding van nuwe moontlikhede in.

As 'n unieke paradigma, bevraagteken Waarderende Ondersoek tradisionele benaderings tot probleemoplossing deur organisatoriese uitdagings met 'n regstellende ingesteldheid te

benader. 'n Regstellende benadering sluit die waardering van die positiewe in, deur op suksesse, sterkpunte en potensiaal te fokus (Cooperrider, Whitney & Stavros, 2008:433). Waarderende Ondersoek sien organisasies as 'n individuele sentrum met onmeetlike verbeelding en moontlikhede, met die voorneme om met oplossings vorendag te kom (Cooperrider, Whitney & Stavros, 2008:16-17).

Ek het 'n kwalitatiewe ontwerp, wat verduidelikend, beskrywend en kontekstueel van aard was, gebruik. Ek het 'n Waarderende Ondersoekbenadering met hierdie ontwerp geïntegreer.

Ek het doelbewuste steekproefneming, wat Polit en Beck (2007:763) definieer as 'n steekproefnemingsmetode waar deelnemers gekies word op grond van wie die meeste inligting oor die tema van die navorsing sal verskaf, wat in hierdie navorsing werkplekondersteuning is. Die dataversamelingsmetodes wat ek gebruik het, was naïewe sketse, klein kerngroep-ondersoeke en individuele onderhoude met lede van die verpleegsbestuur. Die klein kerngroep-ondersoeke het geskrewe antwoorde op die onderhoudskedule van die een-tot-een onderhoude, getranskribeerde terugvoer van die besprekingsfase, die positiewe kernkaart, die nominale groeptegniek, veldnotas en reflektiewe onderhoude ingesluit. Die klein kerngroep-ondersoeke was gegrond op een-tot-een onderhoude wat die deelnemers met mekaar, in groepe van twee, gevoer het, deur van 'n onderhoudskedule gebruik te maak. Tydens die dataontledingsfase het ek twee verskillende tegnieke gebruik om die beskikbare data te ontleed, naamlik die nominale groeptegniek en oopkodering.

Ek het 'n boom as simbool vir werkplekondersteuning in hierdie geestesgesondheidsomgewing gebruik. Die wortels van die boom het die bestuur se vrywilligheid om werkplekondersteuning aan hul werknemers te bied, gesimboliseer. Die stam van die boom het die holistiese benadering tot werkplekondersteuning gesimboliseer. Die takke van die boom het die geïdentifiseerde temas gesimboliseer. Die kategorieë van die ontdekkingsfase is deur die groen blare voorgestel, en die kategorieë van die droomfase deur pienk botsels.

Ek het aanbevelings gemaak met betrekking tot die psigiatriese verpleegsnavorsing, psigiatriese verpleegsopleiding, psigiatriese verpleegsbestuur en psigiatriese verpleegspraktyk. Die doel van hierdie aanbevelings is om meer effektiewe metodes vir

die verskaffing van werkplekondersteuning, uit 'n holistiese perspektief, te fasiliteer, ten einde die geestesgesondheidsbevordering van psigiatriese verpleegpraktisyns wat in hierdie geestesgesondheidsomgewing werk, te fasiliteer.

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CHAPTER 1

OVERVIEW OF THE RESEARCH

"Let the oil of knowledge and of love always ensure that your lamp burns brightly" - Charlotte Searle 1945 (Searle, 2007:VII).

1.1 INTRODUCTION

In order to assure brightly burning lamps for the psychiatric nurses working at the private mental health care setting where I was employed, management included various employee support themes in their in-service training programme for the year 2010. This included lectures from a physiotherapist on posture, a dietician on lifestyle choices and a psychologist on stress management.

It was further clear from a discussion I had with a member of the nursing management that the management of this mental health care setting was committed to the provision of workplace support to their employees. The reasons for being committed to providing workplace support to psychiatric nurses included the promotion of their mental health. Hunnicutt (cited in Dickens, Sugarman & Rogers, 2005:297) showed that nurses experienced less emotional fatigue when they experienced their workplace environment as being supportive. Emotional fatigue or burnout can also lead to psychological resignation which Manion (2009:14) describes as "a state of being". The resignation of psychiatric nurses does not have to be a behavioural action, but can include a psychological absence from their work leading to a decrease in productivity (Manion, 2009:14).

Having witnessed this emotional fatigue or psychological resignation of psychiatric nurses at a specific mental health care setting, I was curious about the particular experience of psychiatric nurses and their wishes regarding workplace support in this private mental health care setting. An additional, but equally important, motivation for me to do the research was the promotion of the mental health of psychiatric nurses working at this specific mental health care setting. I intended to facilitate the promotion of the mental health of these psychiatric nurses by providing them with the opportunity to share their stories regarding workplace support as participants and by proposing recommendations in order to facilitate more effective means to provide workplace support. "Mental health status means the level

of mental well-being of an individual as affected by physical, social and psychological factors and which may result in a psychiatric diagnosis" (Government Gazette, 2002).

Richer, Ritchie and Marchionni (2009) suggest the use of an Appreciative Inquiry approach in research in order to promote original ideas and to provide health care workers with an opportunity to "explore the possibilities for change". The purpose of this research was to conduct an Appreciative Inquiry in order to generate an in-depth understanding of the experiences and wishes of psychiatric nurses regarding workplace support in a private mental health care setting. Psychiatric nurses refer to "mental health care providers meaning a person providing mental health care services to mental health care users and includes mental health care practitioners" (Government Gazette, 2002).

Based on the findings I proposed recommendations to facilitate more effective means to provide workplace support in the identified context with reference to psychiatric nursing research, psychiatric nursing education, psychiatric nursing management and psychiatric nursing practice.

In chapter one, I will present the background and rationale for my research. I will provide the problem statement, the research questions and the research objectives. I will also discuss the paradigmatic perspectives of the research, the research design and the research methodology. I will include a section defining all the main concepts in the research. Finally, I will discuss the significance of this research.

1.2 BACKGROUND AND RATIONALE

Worldwide there are psychiatric nurses who are passionate to influence the lives of mental health care users in their care, yet they struggle with related pressures of inadequate means, challenging behaviours of mental health care users and environments that are stigmatised, lack of availability of suitable services, governmental and guideline concerns, as well as administrative needs (McCabe, 2005:35). Work demands encountered by psychiatric nurses can thus vary from personal stresses related to the interpersonal nature of working with the challenging behaviour of mental health care users to environmental stresses related to an environment reflecting inadequate workplace support. Fink-Samnick (2008:338) explains how the shift from patient care to "the care of the business of health care" guided the increase in the attention to better quality of service resulting in an increase in work demands.

Extensive studies have been conducted worldwide relating to the need for and the occurrence of workplace support for nurses. Bégat, Ellefsen and Severinsson (2005:222) show that occupational stress is increasing among nurses from Britain, Scotland and Norway. Chen, Hwu and Williams (2005:141) indicate that psychiatric nurses from Taiwan are at risk of assault from mental health care users. Tourangeau, McGillis Hall, Doran and Petch (2006:128-9) discuss the satisfaction of Canadian nurses in regards to safety, social and psychological aspects, where aspects relating to the safety of the nurses showed the highest correlation with work satisfaction, followed by the psychological aspects and the social aspects showed a medium correlation with work satisfaction.

The emphasis on the need for workplace support is further highlighted by the shifting focus in health care from illness to health and well-being as a way of preventing the onset of a disease. A supportive workplace milieu is thus one in which there is approachable communication between personnel at all levels, acknowledgment of the efforts of nurses, interdisciplinary consideration, the involvement of nurses in choices concerning care and the environment of the mental health care users, delegation of tasks, personal and professional growth opportunities and encouragement (Stuart & Laraia, 2005:11).

Fagerström (2006:626) writes that the work environment of nurses can be characterised by feelings of chaos; nurses sometimes feel out of control and that their capacity is insufficient. This can be especially relevant to the work environment of psychiatric nurses due to the behavioural challenges that mental health care users pose. According to research performed by Pompili, Rinaldi, Lester, Girardi, Ruberto and Tatarelli, (2006:142) psychiatric nurses are more prone to burnout due to the fact that they require knowledge and skills owing to the unique features of psychiatric nursing.

Knowledge and skills that are required by psychiatric nurses include having to deal with the interpersonal and intrapersonal dynamics of the mental health care users (Uys, 2004:15), in other words “nursing care can be understood as consisting of complex and meaningful caring situations” (Fagerström, 2006:622). This is only possible if the care giver, or the psychiatric nurse in this research, is both physically and mentally healthy, which Fagerström (2006:622) explains as referring to a state of optimal functioning and not just the absence of illness.

The World Health Organisation (cited in Sadock & Sadock, 2007:12) acknowledges that health is “complete physical, mental and social well-being”, where mental health presumes

"the absence of mental disorder". Sadock and Sadock (2007:12) continue to describe mental health as the effective performance of mental activities, relating to thought, behaviour and mood, resulting in the ability to transform, to manage complexity, to function productively and to sustain satisfying relationships.

Stress, on the other hand, which can lead to burnout, can be described as situations that disrupt, or are likely to disrupt, the normal psychological or physiological performance of someone (Sadock & Sadock, 2007:813). Bégat et al. (2005:221) identified various factors that can contribute to experiencing stress in the work environment. These factors include relationships with colleagues, lack of communication, work-related demands and anxiety, lack of motivation, insufficient professional development, feelings of being out of control, ethical conflict, lack of independence in decision-making and conflicting values. These stresses necessitate the implementation of workplace support for psychiatric nurses in order to promote their mental health.

Stuart and Laraia (2005:11) describe the use of oneself as the key therapeutic tool of the psychiatric nurse. Psychiatric nurses work in environments that are varied in location, function, nature and structure, and the overall policy of these organisations regarding workplace support can promote or limit the mental health and potential of psychiatric nurses (Stuart & Laraia, 2005:11). Part of the objective of this research was thus to propose recommendations regarding workplace support in order to promote the mental health of psychiatric nurses working at this mental health care setting.

Stuart and Laraia (2005:11) continue to describe the role of the psychiatric nurse in any mental health care setting as depending on certain factors in the organisation. These factors include the philosophy, goals, prevailing understanding of mental health, needs of the mental health care users, number of available personnel, communication structure, understanding of their individual roles, available resources and presence of effective nurse mentoring.

The role of psychiatric nurses in the context in which the research was conducted included the admission of mental health care users, including the conducting of an assessment interview and the crafting of a nursing care plan, continuous observation and daily interviews with the mental health care users, as well as the writing of reports and the adjusting of the nursing care plans accordingly. Additional tasks of psychiatric nurses include the administering of medication, the coordination of the daily programme of each mental health

care user and the performance of crisis intervention where necessary. Psychiatric nurses in this specific context, namely a private, short-term, in-patient mental health care setting in Gauteng, shared their experiences and wishes regarding workplace support, including the facilitating and restraining factors, with me during the data collection phase of this research.

As a professional psychiatric nurse, I identified the need for effective workplace support for psychiatric nurses working in a private mental health care setting by observing signs of burnout in psychiatric nurses and by listening to employees verbalising their need for workplace support. Observed signs of burnout included emotional exhaustion, feelings of detachment, cynicism and feelings of being ineffective at work.

Spence Laschinger and Leiter (2006:260) attributed signs of burnout in psychiatric nurses to the possible high-client turnover rate, a demanding work environment, lack of sufficient personnel and the resulting working of overtime by the existing personnel, factors that are all present at the mental health care setting where this research had been performed.

As discussed earlier in the introduction section, I identified willingness from management at the mental health care setting where the research was done to explore more effective means of providing workplace support to psychiatric nurses employed by them. The theme of workplace support also correlated with the in-service training theme at the time of the data collection for this research, namely employee support, at the mental health care setting where the research was conducted.

After being introduced to Appreciative Inquiry by one of my supervisors, I decided to use an Appreciative Inquiry framework to explore the experiences and wishes of psychiatric nurses regarding workplace support. The importance of Appreciative Inquiry lies in the appreciation of the behaviour and the responses of individuals instead of focusing on their problems. Appreciative Inquiry is fundamentally about changing our concepts of how changes occur, how people behave and how research can be a factor in this process (Reed, 2007:2).

Appreciative Inquiry was first used by David Cooperrider in 1980 when he used an analysis method of “deliberately appreciating everything of value”, and using this “positive analysis to speculate on the potentials and possibilities for the future”, relating to organisations (Cooperrider, Whitney & Stavros, 2008:XXVII). In other words, Appreciative Inquiry identifies that which is positive in any system and connects or builds on it in order to “heighten energy, vision and action for change” (Cooperrider, et al. 2008:XV).

In order to identify the positive at this mental health care setting regarding workplace support, I wanted to explore the peak experiences of psychiatric nurses regarding workplace support, in other words, I wanted to explore which methods of the existing workplace support psychiatric nurses experienced as being effective. Appreciative Inquiry is used worldwide in initiatives and can be used in combination with other organisational change processes like coaching, leadership development, cultural transformation, strategic planning, team building or the redesign of systems (Cooperrider, et al. 2008:XV).

"Appreciative Inquiry is a philosophy that incorporates an approach … for engaging people at any or all levels to produce effective, positive change" (Cooperrider, et al. 2008:XV). I envisioned this change in workplace support by the implementation of the proposed recommendations discussed in chapter 4.

The 4-D cycle is the process that is employed to facilitate change or to generate the power of Appreciative Inquiry (Whitney & Trosten-Bloom, 2003:6). The 4-D cycle of Appreciative Inquiry consists of four phases, namely the Discovery phase, the Dream phase, the Design phase and the Delivery phase. The Discovery phase involves the appreciation or discovery of that which is positive, life giving or effective; the Dream phase involves the imagining of new possibilities; the Design phase involves the construction of the future; the Delivery phase involves taking action in order to create a better existence (Cooperrider, et al. 2008:6-7).

For this research on workplace support I employed the first two phases of Appreciative Inquiry, namely the Discovery phase and the Dream phase, as part of the data collection, which included the formulation of a positive core map. A positive core map is a visual illustration or summary of the resources, strengths and possibilities of the organisation (Cooperrider, et al. 2008:57). I will discuss the 4-D cycle and the positive core map in detail in chapter 2.

The Appreciative Inquiry approach to organisational development is relatively new, but as Bushe and Kassam (2005:162) proclaim, "Appreciative Inquiry is in a time of exponential growth". Havens, Wood and Leeman (2006) listed various examples of Appreciative Inquiry used in health care organisations, for example at the Lovelace Health System in Albuquerque, to improve vacancy rates, contentment, communication and productive interaction between health professionals.

Jackson, Firtko and Edenborough (2007:7) appeal, "It is timely to explore innovative ways of nurturing and supporting nurses so that they are better able to thrive and sustain satisfying careers even in contexts of organisational difficulty and workplace adversity". This context of organisational difficulty and the need for ways to support psychiatric nurses in the workplace at this mental health care setting led to the formulation of the problem statement below.

1.3 PROBLEM STATEMENT

It is generally agreed (Craft Morgan & Lynn, 2009:402; Lautizi, Laschinger & Ravazzolo, 2009:446; Leiter & Maslach, 2009:331; Seed, Torkelson & Alnatour, 2010:160) that workforce shortages worldwide among nurses are a major concern to health care. The creation of a positive workplace is central to the attraction and retaining of employees where employees are motivated to be loyal towards their employer by a positive work experience rather than by financial rewards (Manion, 2009:XIII). Newton, Kelly, Kremser, Jolly and Billett (2009:392) appeal to researchers that innovative methods are needed to encourage nurses to remain in the profession. In order to identify ways of providing a positive work experience, research on the work environments of nurses increased, however research regarding the correlation between stress and the work environment of psychiatric nurses is limited (Hanrahan, Aiken, McClaine & Hanlon, 2010:198).

A positive work experience can include the provision of workplace support that is tailored to the specific wishes of psychiatric nurses working in a mental health care setting. Mann and Cowburn (2005:156) describe how many of the pressures experienced by psychiatric nurses are from an organisational origin rather than from the involved nature of client care. They continue to describe factors such as lack of training, uncertainty, organisational change and administrative factors, and how ineffective workplace support can be detrimental to the mental health of the psychiatric nurse, ultimately leading to burnout.

A context experienced as providing insufficient workplace support can have a negative impact on the mental health of the psychiatric nurse and can consequently influence the quality of client care in the mental health care setting. McGee (cited in Jackson, et al. 2007:5) suggests that the promotion of personal growth in nurses is essential because "it is not possible for them (psychiatric nurses) to give patients what they do not themselves possess". I would like to extend this to workplace support by proposing that nurses who do not experience support at work would find it challenging to be supportive towards the mental health care users in their care.

If psychiatric nurses experience workplace support to be ineffective, it might even cause them to leave the profession altogether, especially when they are young or inexperienced in psychiatric nursing, as Manion (2009:10) illustrated. It is important for the mental health care setting to minimise the turnover of psychiatric nurses, since Ward and Cowman (2007:454) alert us that there are severe shortages of psychiatric nurses worldwide. There are also economical reasons to ensure the availability of psychiatric nurses. Lacey and Cox (2007) declare that "Adequate and appropriate staffing levels make good business sense and should be vigorously attended to". This is important due to the private nature of this context, as mental health care users in a private context might expect more in terms of the availability of psychiatric nurses.

I could not find relevant information pertaining to workplace support for psychiatric nurses working in mental health care settings in South Africa, by making use of the CINAHL and OVID databases.

The ultimate purpose of this research was to promote the mental health, and in so doing also the overall health, of psychiatric nurses by exploring their experiences and wishes regarding workplace support and by proposing recommendations to facilitate the implementation of more effective ways of providing workplace support.

There are currently 40 registered psychiatric nurses employed by the mental health care setting where I did the research. I will discuss the sample population in detail in chapter 2, paragraph 2.4.2.2, selection of participants. Members from the nursing management at the mental health care setting where the research was conducted were unable to provide me with statistics regarding the turnover rate and vacant posts.

I observed various actions of psychiatric nurses who acted in middle or senior nursing management positions like being physically available in the wards or demonstrating an open door policy, demonstrating a supportive attitude, integrating supportive themes into the in-service training programme and employing more efficient systems, like enhancing the medication administering procedures. These actions were all aimed at providing workplace support to psychiatric nurses working at this demanding private mental health care setting where I did my research. The workload at this setting is demanding due, in part, to the high turnover of mental health care users, with daily admissions and discharges throughout the year.

Despite all the efforts made by management to employ effective actions in order to provide workplace support to psychiatric nurses, I observed signs of burnout among psychiatric nurses. I observed an absence of interest in work, conflict among nursing colleagues, irritability and verbalisations of feeling tired and not receiving support. Okun and Kantrowitz (2008:302) describe burnout as feeling exhausted, being unable to concentrate, being irritable, experiencing altered sleep and eating habits and the absence of motivation and interest in work.

The problem that I identified was this apparent contradiction or disparity between the attempt of management to provide workplace support and the experiences of psychiatric nurses with regard to the available workplace support. This made me curious about the implication and effect of the current workplace support systems and more specific the experiences of psychiatric nurses with regards to current workplace support and the effectiveness thereof according to psychiatric nurses.

I was also conscious of the fact that those experiences may vary from examples given in literature. As Dickens et al. (2005:302) contended, I also suspected that nurses in one context might experience their working environment differently than reported in comparable research findings. I was also curious to explore the wishes of psychiatric nurses with regard to workplace support at this specific mental health care setting in order to propose specific recommendations based on their contextual experience.

My purpose was to conduct an Appreciative Inquiry to generate an in-depth understanding of the experiences and wishes of psychiatric nurses regarding workplace support in order to propose recommendations that may contribute to the promotion of the mental health of psychiatric nurses in a private mental health care setting.

1.4 RESEARCH QUESTIONS

Considering the discussed problem statement, I asked the following research questions based on the Appreciative Inquiry approach:

- what are psychiatric nurses' experiences of workplace support in a private mental health care setting, and

- what wishes could psychiatric nurses have regarding workplace support in a private mental health care setting?

1.5 PURPOSE AND OBJECTIVES OF THE RESEARCH

The purpose of the research was to conduct an Appreciative Inquiry to generate an in-depth understanding of the experiences and wishes of psychiatric nurses regarding workplace support in a private mental health care setting.

The objectives of the research were to:

- explore and describe the experiences of psychiatric nurses of workplace support in a private mental health care setting,

- explore and describe the wishes of psychiatric nurses regarding workplace support in a private mental health care setting, and

- propose recommendations regarding workplace support with reference to psychiatric nursing research, psychiatric nursing education, psychiatric nursing management and psychiatric nursing practice, in order to facilitate more effective means to provide workplace support and to facilitate the promotion of the mental health of psychiatric nurses.

1.6 PARADIGMATIC PERSPECTIVES

Polit and Beck (2008:761) define a paradigm as a philosophical statement that directs the style of inquiry of the researcher into phenomena. The paradigmatic perspectives consist of the meta-theoretical perspective, the theoretical perspective and the methodological perspective.

I will discuss the Theory for Health Promotion in Nursing as the meta-theoretical perspective and Appreciative Inquiry as the theoretical perspective, along with the assumptions for each perspective individually. Finally I will discuss the methodological perspective of this research.

1.6.1 Meta-theoretical perspective

Meta-theoretical refers to the theoretical foundation of the research (Polit & Beck, 2008:683). The meta-theoretical perspective that guided this researcher was the Theory for Health Promotion in Nursing.

1.6.1.1 Theory for health promotion in nursing

The essential purpose of this theory is health promotion for an individual, group, family or community (University of Johannesburg, 2009:4). Health promotion for an individual, group, family or community transpires through the mobilisation of resources, including the promotion, maintenance and restoration of health (University of Johannesburg, 2009:5). The nursing process is used to provide care for an individual, group, family or community and includes activities of "assessment, planning, implementation and evaluation" as integrated and continuous activities (University of Johannesburg, 2009:5).

The individual is in interaction with the environment which consists of an internal and external environment. The internal environment comprises the dimensions of body, mind and spirit of the individual. The external environment comprises the physical, social and spiritual dimensions of the individual. The interactions between these dimensions in the environment of the individual influence the health status of the individual on a continuum (University of Johannesburg, 2009:5).

The experiences and wishes regarding the providing of workplace support pertaining to the internal and external environments of the psychiatric nurse will be examined in order to promote the mental health of the psychiatric nurse. Resources can be mobilised in the external environment in terms of workplace support that might facilitate mental health by strengthening resources in the internal environment of the psychiatric nurse.

1.6.1.2 Assumptions of the theory for health promotion in nursing

The following assumptions relating to the person, health, the environment, nurse and nursing, adapted in a context of psychiatric nursing, underlie the Theory for Health Promotion in Nursing (University of Johannesburg, 2009:4) and will provide the overarching meta-theoretical perspective in this research.

The psychiatric nurse as a person is holistically in interaction with the environment. The environment consists of an internal and external environment. According to the Theory for Health Promotion in Nursing, "the internal environment consists of dimensions of body, mind and spirit" and "the external environment consists of the physical, social and spiritual dimensions" (University of Johannesburg, 2009:5). "Body" includes all the physiological processes and anatomical structures, "mind" includes emotional, intellectual and volitional processes and "spirit" includes the relationships and conscience of the individual (University of Johannesburg, 2009:6). "Physical" includes chemical and physical structures, "social" includes all the human resources and "spiritual" includes the religious aspects and values of the individual (University of Johannesburg, 2009:6-7).

In this research I took care to explore the holistic experience of each participant, in accordance with the Theory for Health Promotion in Nursing, in order to obtain a holistic picture of experiences relating to workplace support. The holistic experience of psychiatric nurses is important, since they work from a holistic viewpoint in the providing of care to the mental health care users at this mental health care setting. See chapter 3, paragraph 3.3.3, holistic approach to workplace support, for a discussion of holistic support relating to the internal and external environments of the psychiatric nurse.

I did not formally define workplace support in terms of an internal or external environment during the core group inquiries, in order to obtain the personal description and explanation of workplace support of each participant relating to her personal experiences of workplace support in the internal and external environments. A core group inquiry, which is one of the ways of engagement in Appreciative Inquiry, is one of the data collection methods that I used in this research which involve participants who conducted one-on-one interviews with each other in pairs (Whitney & Trosten-Bloom, 2003:32) using an interview schedule (addendum E).

The health of the individual, or the mental health of the psychiatric nurse in this research, is an interactive process in these environments. The promotion of mental health is integrally linked to the dynamic interaction between the psychiatric nurse and the environment. Recommendations on how to facilitate more effective means of providing workplace support, with reference to psychiatric nursing management, research, education and practice, can aid in the mobilisation of resources in the internal and external environments of psychiatric nurses.

The aim of nursing is to facilitate health promotion as an interactive process between the nurse, as a therapeutic and sensitive professional, and the client (University of Johannesburg, 2009:4-5). In the context of this research health will refer to mental health. Health promotion will refer to the promotion of the mental health of the psychiatric nurse by the implementation of workplace support by members of senior and middle nursing management of this mental health care setting. This facilitation includes the "creation of a positive environment and mobilisation of resources, as well as the identification and bridging of obstacles" by demonstrating "knowledge, skills, attitudes and values" (University of Johannesburg, 2009:7).

According to the Theory for Health Promotion in Nursing the nurse is seen as a therapeutic and sensitive professional who demonstrates skills, knowledge and values in order to facilitate health promotion (University of Johannesburg, 2009:4). In this research, members of management, including senior and middle management, of this private mental health care setting can mobilise the resources with regard to workplace support, create a positive environment relating to workplace support and identify and overcome obstacles, thus implementing aspects of the nursing process to promote the mental health of psychiatric nurses employed by them.

The Theory for Health Promotion in Nursing describes the use of the nursing process as a methodology in providing nursing care and includes phases of assessment, planning, implementation and evaluation as integrated and continuous activities (University of Johannesburg, 2009:5). I linked the discovery and dream phases of Appreciative Inquiry to the assessment phase of the nursing process, since the collection of data relating to the identification of facilitating factors is central, both in the assessment phase of nursing and in the discovery and dream phases of Appreciative Inquiry. The discovery and dream phases are two phases of the four phases of the 4-D Cycle of Appreciative Inquiry which are "the process used to generate the power of Appreciative Inquiry" (Whitney & Trosten-Bloom, 2003:6).

1.6.2 Theoretical perspective

According to Polit and Beck (2008:142) the theoretical perspective is the all-embracing conceptual foundation of research. Appreciative Inquiry was the theoretical and methodological perspective that guided this research.

1.6.2.1 Appreciative inquiry

Appreciative Inquiry developed from the Social Constructionist paradigm which is based on the belief that social experiences are socially constructed and do not result from any objective principles (Terre Blanche, Durrheim & Painter, 2006:558). Experiences can thus only be understood by deconstructing their essential meanings. Cooperrider et al. (2008:14) continue to comment that Appreciative Inquiry uses the concept that a social system constructs or shapes its own reality by using a positive perspective.

As a unique paradigm, Appreciative Inquiry questions traditional approaches to problem solving by accepting organisational challenges using an affirmative approach. An affirmative approach includes an appreciation of the positive by focussing on successes, strengths and potential (Cooperrider, et al. 2008:433). Appreciative Inquiry views organisations as individual centres of immense imagination and possibilities, intended to function as solutions (Cooperrider, et al. 2008:16-17).

Traditionally research and intervention were seen as different and disconnected processes. By using the Appreciative Inquiry approach, research in itself can facilitate social transformation. Researchers acquire knowledge by the kind of questions they ask and the way in which they ask these questions. Appreciative Inquiry suggests that problems can be created simply by asking questions regarding problems. If the researcher, however, asks questions concerning the positive aspects of experiences, possibilities can be created (Reed, 2007:VIII).

Appreciative Inquiry uses a process known as the 4-D cycle to generate change, based on the idea that individuals and organisations evolve according to what is being studied. The 4-D cycle consists of the discovery phase, the dream phase, the design phase and the destiny phase. Whitney and Trosten-Bloom (2003:6) explained that Appreciative Inquiry focuses attention on the positive potential, or positive core, through the discovery phase, the dream phase, the design phase and finally the destiny phase. The positive core of an organisation includes hopes, dreams, strengths and possibilities (Whitney & Trosten-Bloom 2003:15).

Reed (2007:32-33) describes the discovery phase as a quest to find out more about the organisation, the dream phase is where participants develop ideas about the future, the design phase is where participants construct future plans and the delivery phase involves the planning of specific activities and making of commitments. Cooperrider et al. (2008:101)

illuminate the four phases by formulating a question for each phase. The discovery phase question is: “what gives life?”; the dream phase question is: “what might be?”; the design phase question is: “how can it be?”; and the destiny phase question is: “what will be?”. I will discuss these phases in more detail in chapter 2.

I compared the first two phases of Appreciative Inquiry, namely the discovery phase and the dream phase, with the first phase of the nursing process according to the Theory for Health Promotion in Nursing, namely the assessment phase. The reason for this comparison stemmed from one of the objectives of this research, namely to facilitate more effective means to provide workplace support and to promote the mental health of the psychiatric nurse, which resonates with an assumption of the Theory for Health Promotion in Nursing which states that the aim of nursing is to facilitate health promotion. Assessment involves the examination of the facilitating and interfering aspects in the internal and external environments of the individual (University of Johannesburg, 2009:8). The discovery and dream phases of the 4-D cycle of Appreciative Inquiry equally involve the examination of positive aspects in both the internal and external environments.

Based on the scope of the mini-dissertation and due to time constraints I decided to use only the first two stages of Appreciative Inquiry, namely the discovery and dream phases. The implementation and evaluation of the findings through the final two phases of design and destiny fell outside the research design as being exploratory and descriptive. The purpose of the research was to conduct an Appreciative Inquiry in order to generate an in-depth understanding of the experience and wishes of psychiatric nurses regarding workplace support in a private mental health care setting.

Attentive listening, which does not exclude negative information from the participants, is part of this process, subsequently moving the participant towards an appreciation of potential (Reed, 2007:IX). The process of giving the participating psychiatric nurses an opportunity to verbalise their experiences and wishes regarding workplace support produced a space that was conductive for the promotion of their mental health, as evidenced by the positive feedback on the opportunity to voice their experiences, as given by the participants after the small core group inquiries. This was evident when participants in this research verbalised an appreciation of the existing workplace support and demonstrated a positive attitude when verbalising their wishes for additional workplace support.

1.6.2.2 Assumptions of appreciative inquiry

Whitney and Trosten-Bloom (2003:54-55) discuss eight principles that guide the assumptions underlying Appreciative Inquiry. These principles are the constructionist principle, the simultaneity principle, the poetic principle, the anticipatory principle, the positive principle, the wholeness principle, the enactment principle and the free-choice principle.

According to Whitney and Trosten-Bloom (2003:54), the constructionist principle affirms that reality is subjective and individually constructed through narratives. The simultaneity principle indicates that inquiry is intervention and change can be facilitated by asking questions. The poetic principle shows how organisations are continuous sources of knowledge, and how the subject of research can be transformational in itself.

According to the anticipatory principle, individual systems will move in the direction that is envisioned and positive images can create positive actions. The positive principle shows how positive questions can strengthen the positive foundation including capabilities, strengths, skills, resources and assets. According to the wholeness principle, the whole organisation must be involved and wholeness facilitates the best in individuals and organisations. The enactment principle encourages individuals to be the change they aspire to and states that transformation takes place when there is a representation of the ideal future. The free-choice principle acknowledges the benefit of giving people autonomy (Whitney & Trosten-Bloom, 2003:55).

Reed (2007:27-28) discusses eight assumptions of Appreciative Inquiry that developed from these principles. I will discuss these assumptions by referring to the principles of Appreciative Inquiry, since the principles and assumptions of Appreciative Inquiry can be viewed as integrated. The assumptions are: in every organisation something works; what we focus on becomes our reality; there are multiple realities; the act of asking questions can influence the organisation; parts of the past must be carried with in order for organisations to journey to the future; we must carry the best of the past with us; it is important to value differences; our language creates our reality.

The first assumption is that there is something effective in every group, organisation or society, in other words something is working (Reed, 2007:27). This can be correlated to the positive principle of Appreciative Inquiry, which suggests that a positive focus will deeply

engage individuals. I aimed to support the positive principle by using positive questions. I also supported the principle during the feedback stage by encouraging positive ideas using communication techniques. The positive principle was also evident in the acknowledgement that methods were already employed to facilitate workplace support to psychiatric nurses. I will discuss this in more detail under the research methods section in chapter 2.

The second assumption describes how our reality develops from our focus (Reed, 2007:27-28), meaning that focus on the positive will direct a constructive realm. This can be compared to the anticipatory principle, which explains how systems move in the direction of the image they have of the future and the more positive the future image is, the more positive current actions will be. I aimed to incorporate this assumption by means of the positive focus of the research and the subject, namely workplace support. The reality of the participants regarding workplace support might have adjusted by focussing on actions that the participants experienced as being effective and supportive, thus positively influencing their attitudes and promoting their mental health.

The third assumption of numerous realities shows how there are different realities and that reality is shaped in the present (Reed, 2007:28). This assumption correlates with the constructionist principle that describes how different individuals can have diverse interpretations of their world, which I applied by exploring the distinctive experiences and wishes of each psychiatric nurse regarding workplace support individually. I also gave participants the opportunity to share their individual narratives during the discussion phase of the small core group inquiries.

I acknowledged that the need for workplace support and participant's individual experiences thereof and their individual wishes regarding workplace support in this specific mental health care setting might be different from each other and distinct from another mental health care setting concerning some aspects.

The nominal group technique, as part of the data analysis, which was used during the small core group inquiries, was an indication of how different participants preferred different themes regarding workplace support. Strydom (2005:419) suggest the use of the nominal group technique in order to prioritise the opinions of people regarding a challenge. The nominal group technique will be discussed in detail in chapter 2.

The fourth assumption is that individuals, groups or communities can be influenced just by

being questioned (Reed, 2007:28). This assumption can be linked to the simultaneity principle of Appreciative Inquiry, which suggests that questioning facilitates thinking and that thinking can facilitate a change in behaviour. I aimed at stimulating this thinking regarding workplace support by using carefully designed questions during the data collection in order to obtain an in-depth description of the experiences and wishes of participants regarding workplace support. These questions will be discussed in more detail in chapter 2, under data collection methods. I facilitated appreciation of the potential of psychiatric nurses by giving participants the opportunity to verbalise their experiences and wishes and to be heard. In order for interventions in Appreciative Inquiry to be generative, the questions ought to have the following qualities: questions that are unexpected or unusual, questions that extract meaningful responses or reveal energy, questions that build relationships by encouraging discussions and finally questions that require participants to view reality in a different way (Bushe, 2007:6). I integrated these guidelines into the formulation of the questions and into the discussion phases of the small core group inquiries.

The fifth assumption shows that when individuals or groups are allowed to incorporate parts of the known or the past they will be more secure when they move to the unfamiliar or the future. I focused on previous positive and effective systems to provide workplace support in the discovery phase in order to incorporate positive parts of the past.

The sixth assumption correlates with the previous by stating that individuals or groups should carry the most excellent from the known or the past to the unfamiliar or the future. This assumption again correlates with the positive principle. I aimed to strengthen participants' recollection of the best experiences they had relating to workplace support by allowing them to complete naïve sketches before the small core group inquiries, asking participants to write a story or narrative concerning a peak experience at work that made them feel most supported.

The seventh assumption stresses the importance of differences in individuals or groups (Reed, 2007:28). I motivated every participant to contribute in order to give everybody a chance to be heard and to make participants aware of diverse experiences. The methods of data collection that I used, including the small core group inquiries with psychiatric nurses and the individual interviews with members of nursing management, also highlighted the differences in experiences and wishes between psychiatric nurses and nursing management.

The eighth assumption shows how our narratives or stories construct our reality. This assumption can be connected to both the constructionist and the poetic principles. I worked from a positive framework according to Appreciative Inquiry methods, asking constructive questions and, as a result, facilitating positive narratives and feedback from participants.

1.6.3 Methodological perspectives

The methodological question is directed to how or in what manner the researcher should go about to obtain knowledge (Polit & Beck, 2008:13). A qualitative design was used during this research. Fouché and Delport (2005:74) explain the characteristics of a qualitative design as holistic and in-depth with a flexible design. Polit and Beck (2008:14) provided the assumptions set out below with regard to the naturalistic design.

Reality is mentally constructed by individuals, and these many realities are subjective. This assumption of qualitative research correlates with the constructionist principle of Appreciative Inquiry which refers to the subjectivity of reality and the construction of individual realities through narratives. My objectives were to explore the unique experience and wishes of each participant regarding workplace support in order to understand the experiences of the participants. This correlates with the Appreciative Inquiry assumption of multiple realities.

Research findings result from the interactive process between the researcher and the participants. This assumption can correlate with the simultaneity principle of Appreciative Inquiry to some extent, which proposes that “inquiry is intervention” (Whitney & Trosten-Bloom, 2003:54). Interactions with the participants are thus central to my understanding of the experiences and wishes of the participants relating to workplace support, as it forms part of the intervention.

During the small core group inquiries I used a co-facilitator or a discussion leader in order to achieve triangulation and to facilitate the group discussions and the nominal group technique while I took field notes and drew the positive core maps. The discussion leader was skilled in the facilitation of the 4-D cycle of Appreciative Inquiry. The independent discussion leader and I used different communication techniques during feedback and interviews, like paraphrasing, questioning, interpretation and summarising in order to verify our understanding of the data. I will discuss the data collection methods in detail in chapter 3.

Subjectivity of the researcher is expected and the researcher becomes part of the process. Since I was employed at the mental health care setting where the research occurred, my own subjectivity was inevitable to some extent. Polit and Beck (2008:15) maintain that in order for the qualitative researcher to understand and interpret the voices of the participants, the researcher requires subjective interaction with the participants. In light of my own involvement and subjectivity I employed various triangulation techniques during the data collection and during the analysis process to verify my findings. I will discuss the triangulation techniques that were used during this research in chapter 2.

I used a holistic approach, in accordance with the Theory for Health Promotion in Nursing, which correlates with the wholeness principle of Appreciative Inquiry. I aimed to explore a wide range of experiences and wishes relating to workplace support during the data collection phase. I did this by not giving participants a formal definition of workplace support and by encouraging participants to think of different experiences and wishes that they felt were supportive.

The processes that the researcher uses are inductive in nature or generalisations developed from specific observations (Polit & Beck, 2008:13). Ideas thus emerge from the data collection and there is no hypothesis testing (Reed, 2007:53). The insight of participants transpires through the experiences of the participants, and this insight of participants correlates with the simultaneity principle of Appreciative Inquiry which Whitney and Trosten-Bloom (2003:54) define as “inquiry creates change”.

I used a flexible design. This correlates with an Appreciative Inquiry design that does not determine interventions before, but rather plans and formulates interventions in a flexible design as the project develops (Reed, 2007:54). Results of a qualitative design are context-bound. I used a contextual design aimed at psychiatric nurses from a specific private mental health care setting in Gauteng and did not aim to generalise the findings.

The information in this research comprised a narrative form. Participants conveyed their stories by writing naïve sketches, discussing and answering the questions during the one-on-one interviews, further explaining their stories during the feedback and discussion phase and by conveying their experiences to me during the individual interviews. A narrative is both a way of relating to and explaining experiences (Reed, 2007:145).

1.7 CLARIFICATION OF MAIN CONCEPTS

I discussed all the main concepts of the research that are presented in the title.

1.7.1 Appreciative Inquiry

Appreciative Inquiry incorporates two aspects, namely "appreciate" and "inquiry". Appreciate means to assess and encourage excellence in people and their surroundings, including strengths, successes and potential. It is also to recognise the life-giving factors in living systems (Cooperrider, et al. 2008:1). Whitney and Trosten-Bloom (2003:2) define the twofold meaning of the word appreciate as a performance of recognition and that of adding significance. They continue to define appreciate as the recognition of the best in individuals and the environment, as the recognition of life-giving energy, as the acknowledgement of power in the past and the present and to enhance value.

Inquire means to be open to and explore new capabilities and possibilities through suitable, purposeful and positive questioning (Cooperrider, et al. 2008:1). Inquiry also refers to a process of investigation and finding, to querying, to learning and to exploring (Whitney & Trosten-Bloom, 2003:2).

Cooperrider et al. (2008:XI) define Appreciative Inquiry as "a form of transformational inquiry that selectively seeks to locate, highlight and illuminate the life-giving forces of an organisation's existence". It is founded on the principle that systems are imagined and formed by those working in them (Cooperrider, et al. 2008:XI). Appreciative Inquiry is thus the collective exploration for the optimal in personal and organisational functioning. It explores a system at its optimal functioning and foresees and reinforces future potential (Cooperrider, et al. 2008:3). Bushe and Fraser (2007:30) however emphasise that Appreciative Inquiry is "not just about the positive", but about generativity through pursuing new ideas that will change the social construction of the truth.

I used Appreciative Inquiry both as a theoretical and methodological perspective in this research, focusing on appreciating the positive responses, successful systems or effective interventions of psychiatric nurses in relation to workplace support without disregarding the negative experiences and responses, as Appreciative Inquiry does not only focus on the positive responses. Participants were motivated and given the opportunity to think of new ideas in the dream phase of the core group inquiries.

1.7.2 Experience

Coetzee and Schreuder (2010:517) define **experience** as observation or direct involvement in events that forms the basis for understanding and comprehension.

Remen (cited in Whitney & Trosten-Bloom, 2003:70) explains that each individual experiences an event differently and that narratives are comprehension and not the event self. In this research, experience thus included participants' interpretations of what they have personally seen, heard, felt and been involved in concerning workplace support.

1.7.3 Private mental health care setting

Private mental health care setting is a health organisation that provides care, treatment and rehabilitation for mental health care users (Government Gazette, 2002). Private meaning that mental health care is offered for financial gain (Searl, 2007:151). In this research, private mental health care setting refers to a private psychiatric clinic in Gauteng with a client capacity of 150 beds, with a short-term treatment programme offering treatment, care and rehabilitation for profit.

1.7.4 Psychiatric nurse

Psychiatric nurse is a registered nurse who has been qualified to provide mental health care, treatment and rehabilitation services to mental health care users (Government Gazette, 2002).

In this research it referred to a psychiatric nurse registered with the South African Nursing Council, who is providing mental health care to users and who is permanently employed in a private mental health care setting. All the participants in this research were psychiatric nurses, including participants in the small core group inquiries and participants from nursing management with whom I conducted individual interviews. Psychiatric nurses that formed part of nursing management included middle and senior nursing management. I discussed the inclusion criteria of participants in chapter 2.

1.7.5 Workplace support

Workplace support in this research means all the different interventions that can be

implemented by management at the place of work. Interventions can be in the form of establishing group cohesion, providing a good working environment, as well as assistance and encouragement from peers and supervisors (Booyens, 2008:364).

1.8 RESEARCH DESIGN

I used a qualitative design which was exploratory, descriptive and contextual, following an Appreciative Inquiry approach. Polit and Beck (2008:763) define qualitative research as an investigation that is holistic and in-depth through narratives, with a flexible design. I will describe the research design in more detail in chapter 2.

1.9 RESEARCH METHODS

In chapter 2 the research methods used are discussed in detail, including the research setting, a private mental health care setting and the selection of participants, which was purposeful sampling involving psychiatric nurses and members of nursing management.

The data collection was conducted using an Appreciative Inquiry approach and included naïve sketches, one-on-one interviews between participants, feedback and a group discussion, positive core maps, field notes, reflective interviews and individual interviews with members of nursing management. A discussion leader co-facilitated the small core group inquiries. I used an interview schedule (addendum E) during the small core group inquiries where psychiatric nurses conducted one-on-one interviews with each other (Whitney & Trosten-Bloom, 2003:116) and used the same interview schedule for individual interviews with members of nursing management (Reed, 2007:80).

I only employed the first two stages of the 4-D cycle, namely the discovery phase and the dream phase, as previously justified in paragraph 1.6.2.1, Appreciative Inquiry.

I used two data analysis methods, namely the nominal group technique and open coding. See the table summarising the data collection and data analysis methods in chapter 2.

1.10 METHODS TO ENSURE TRUSTWORTHINESS

I used the standards described by Lincoln and Guba (cited in Polit & Beck, 2008:539-540) as criteria to ensure trustworthiness in this research, namely credibility, dependability,

confirmability, transferability and authenticity. I will discuss these methods in detail in chapter 2.

1.11 ETHICAL CONSIDERATIONS

The ethical considerations relevant to this research were described according to the model of Burkhardt and Nathaniel (2002), namely autonomy, beneficence, non-maleficence, veracity, confidentiality, justice and fidelity. I also used the Declaration of Helsinki. I will discuss these ethical considerations in more detail in chapter 2.

1.12 SIGNIFICANCE OF THIS RESEARCH

Reed (2007:107) describes the significance of Appreciative Inquiry research by referring to the transformative nature of a discussion concerning peak past experiences. I envisioned that the use of Appreciative Inquiry as a research approach in this research will enhance collaboration of psychiatric nurse practitioners and stakeholders by providing psychiatric nurses with a voice regarding their experiences of and wishes for workplace support, and ultimately facilitate the promotion of the mental health of psychiatric nurses.

Participants had the opportunity to be empowered and to develop themselves beyond the parameters of the research related to their engagement in the Appreciative Inquiry process (Reed, 2007:107).

Additionally, a contribution will be made with regard to psychiatric nursing research, psychiatric nursing education, psychiatric nursing management and psychiatric nursing practice. Finally the mental health of psychiatric nurses can be promoted by the implementation of the recommendations discussed in chapter 4.

1.13 OUTLINE OF CHAPTERS

Chapter 1: OVERVIEW OF THE RESEARCH

Chapter 2: RESEARCH DESIGN AND METHODS

Chapter 3: DISCUSSION OF THE FINDINGS AND LITERATURE CONTROL

Chapter 4: JUSTIFICATION, LIMITATIONS, CONCLUSIONS AND RECOMMENDATIONS

1.14 SUMMARY

In this chapter, I highlighted the need of psychiatric nurses for workplace support in order to keep their lamps burning by promoting their mental health. I clarified the purpose and objectives of this research in terms of exploring and describing the experiences and wishes of psychiatric nurses regarding workplace support in order to propose recommendations regarding workplace support.

Following the background of the research, I discussed the problem statement, the research questions and the objectives of the research. I deliberated on the paradigmatic perspectives relevant to this research, including the Theory for Health Promotion in Nursing as the meta-theoretical perspective and Appreciative Inquiry as the theoretical perspective. The methodological perspectives were discussed. I also clarified the main concepts that are presented in the title of this research. Finally, I discussed the significance of this research on workplace support.

CHAPTER 2

RESEARCH DESIGN AND METHODS

2.1 INTRODUCTION

In this chapter I will discuss the research design and the research methods I used during the research on the experiences and wishes of psychiatric nurses regarding workplace support in a private mental health care setting. I will also discuss the qualitative, explorative, descriptive and contextual design I used for the research and elaborate further on Appreciative Inquiry approach, focussing on the discovery and dream phases.

I will explain the research methods in terms of the research setting, the selection of participants, the data collection and the analysis methods. Additionally I will discuss the strengths and weaknesses of the research methods employed during the research process. The methods to ensure trustworthiness referring to credibility, dependability, confirmability, transferability and authenticity will also be discussed. Finally I will examine the ethical considerations of this research by referring to autonomy, beneficence, non-maleficence, veracity, confidentiality, justice and fidelity.

2.2 PURPOSE AND OBJECTIVES OF THE RESEARCH

The overall purpose for performing this research was to conduct an Appreciative Inquiry in order to generate an in-depth understanding of the experiences and wishes of psychiatric nurses regarding workplace support in a private mental health care setting.

The objectives for the research were to:

- explore and describe the experiences of psychiatric nurses regarding workplace support in a private mental health care setting,

- explore and describe the wishes of psychiatric nurses regarding workplace support in a private mental health care setting, and

- propose recommendations regarding workplace support with reference to psychiatric nursing research, psychiatric nursing education, psychiatric nursing management and psychiatric nursing practice in order to promote the mental health of psychiatric nurses working in a private mental health care setting.

2.3 RESEARCH DESIGN

A research design is the overall strategy used by the researcher in order to address the research questions and to enhance the reliability of the research (Polit & Beck, 2008:65). I used a qualitative design which was exploratory, descriptive and contextual. I integrated an Appreciative Inquiry approach into this design.

2.3.1 Qualitative design

Polit and Beck (2008:763) describe qualitative research as in-depth and holistic, with a flexible design. A qualitative research design involves an integration of data collection approaches, it is flexible, it aims to be holistic, it necessitates an engaged researcher who becomes the research instrument and finally it involves ongoing data analysis to determine strategies (Polit & Beck, 2008:219).

The interpretation of views given by participants is essential when conducting qualitative research, and information is optimised when the closeness between the researcher and the participants is minimised. The findings from qualitative research are the result of interaction between the researcher and the participants (Polit & Beck, 2008:15). The purpose of the research was to conduct an Appreciative Inquiry in order to generate an in-depth understanding of the experiences and wishes of psychiatric nurses regarding workplace support in a private mental health care setting.

Reed (2007:54) suggests that the research design which most closely reflects an Appreciative Inquiry approach is a qualitative design, since Appreciative Inquiry deals with "naturally occurring phenomena" and uses a flexible design. A qualitative design also employs a flexible design and aims to obtain a holistic description of phenomena.

2.3.2 Exploratory design

Polit and Beck (2008:20) describe exploratory research as an enquiry into the nature of

phenomena. The aim of an exploratory design is to increase the understanding of a situation, an individual, a community or an experience (Fouché & De Vos, 2005:134). This correlates with the objectives of the research, namely to explore the experiences and wishes of psychiatric nurses regarding workplace support in a private mental health care setting. My aim was to conduct an in-depth inquiry into the holistic experience of workplace support, correlating with the Theory for Health Promotion in Nursing.

Appreciative Inquiry as a research approach is also concerned with the interpretation and meaning of phenomena as well as with an understanding of the social world (Reed, 2007:65).

2.3.3 Descriptive design

Polit and Beck (2008:752) explain descriptive research as the accurate interpretation and portrayal by the researcher of the circumstances of phenomena and the characteristics of individuals or communities.

I used communication techniques, like paraphrasing, questioning, interpretation and summarising (Johnson, 2006:133) and member checking throughout the data collection process in order to ensure that my description and interpretation of the data obtained were accurate. (Please see 2.4.4.4, Role of the researcher). Polit and Beck (2008:758) describe member checking as a validating method employed through discussions with participants in order to assess the accuracy of the data collected. In order for me to accurately represent the experience and wishes of the participants, I provided some examples of the original data of the verbatim transcriptions, in the form of direct quotations, in chapter 3. Reed (2007:59) explains how an Appreciative Inquiry approach is concerned with describing or revealing phenomena.

2.3.4 Contextual design

Mason (2005:165) explains that a contextual design is guided by a holistic exploration in context. Reasons for using a contextual design might include looking for distinctiveness or wanting to understand a specific context (Mason, 2005:166). I described the experience of workplace support in a specific context, namely a private mental health care setting in Gauteng, and did not intend to make generalisations with regard to other settings. Psychiatric nurses in this context experience unique stresses due to the nature of the mental

health care users and the nature of mental health care provision. Psychiatric nurses in this specific context may require unique methods of facilitating workplace support. I provided additional details concerning the research context under the heading research setting and entrée in this chapter in paragraph 2.4.1. Reed (2007:65) also explains that an Appreciative Inquiry approach focuses on specific situations or settings and does not intend to generalise the findings.

2.3.5 Appreciative Inquiry approach

Appreciative Inquiry is more an approach than a distinct methodology. The relevant employment of Appreciative Inquiry can be determined by considering the purpose, the type of engagement and the inquiry approach employed (Whitney & Trosten-Bloom, 2003:24). Although it is complex to disconnect the intervention and research components of Appreciative Inquiry, I wanted to use it firstly as a research approach in order to explore and describe the experiences and wishes of psychiatric nurses relating to workplace support.

The first two phases of the 4-D cycle of Appreciative Inquiry which I implemented, namely the discovery phase and the dream phase, also correlate with research, as Reed (2007:124) also indicated by explaining that the discovery phase and the dream phase of Appreciative Inquiry "are strikingly relevant to research". All four phases of the 4-D cycle of Appreciative Inquiry can, however, be used to structure data collection by focusing and sequencing the data collection phase (Reed, 2007:124).

The focus was on a developing design, since Reed (2007:54) explains that planning interventions in Appreciative Inquiry is a continuous process as the research evolves and cannot be formulated beforehand. Appreciative Inquiry is flexible due to the responsive nature of the approach to events and contexts (Reed, 2007:123). This links to qualitative research based on the notion of an emerging design.

Appreciative Inquiry is the "exploration of what gives life to human systems when they function at their best" (Whitney & Trosten-Bloom, 2003:1). This move towards organisational and personal transformation is founded on the idea that change can be facilitated by asking questions and having discussions concerning successes, strengths, dreams and expectations (Whitney & Trosten-Bloom, 2003:1).

2.3.5.1 The 4-D cycle of Appreciative Inquiry

The method that is used to construct the potential of Appreciative Inquiry is the 4-D cycle. The 4-D cycle consists of the discovery phase, the dream phase, the design phase and the delivery phase, as shown in Figure 2.1, Diagram of Appreciative Inquiry 4-D cycle.

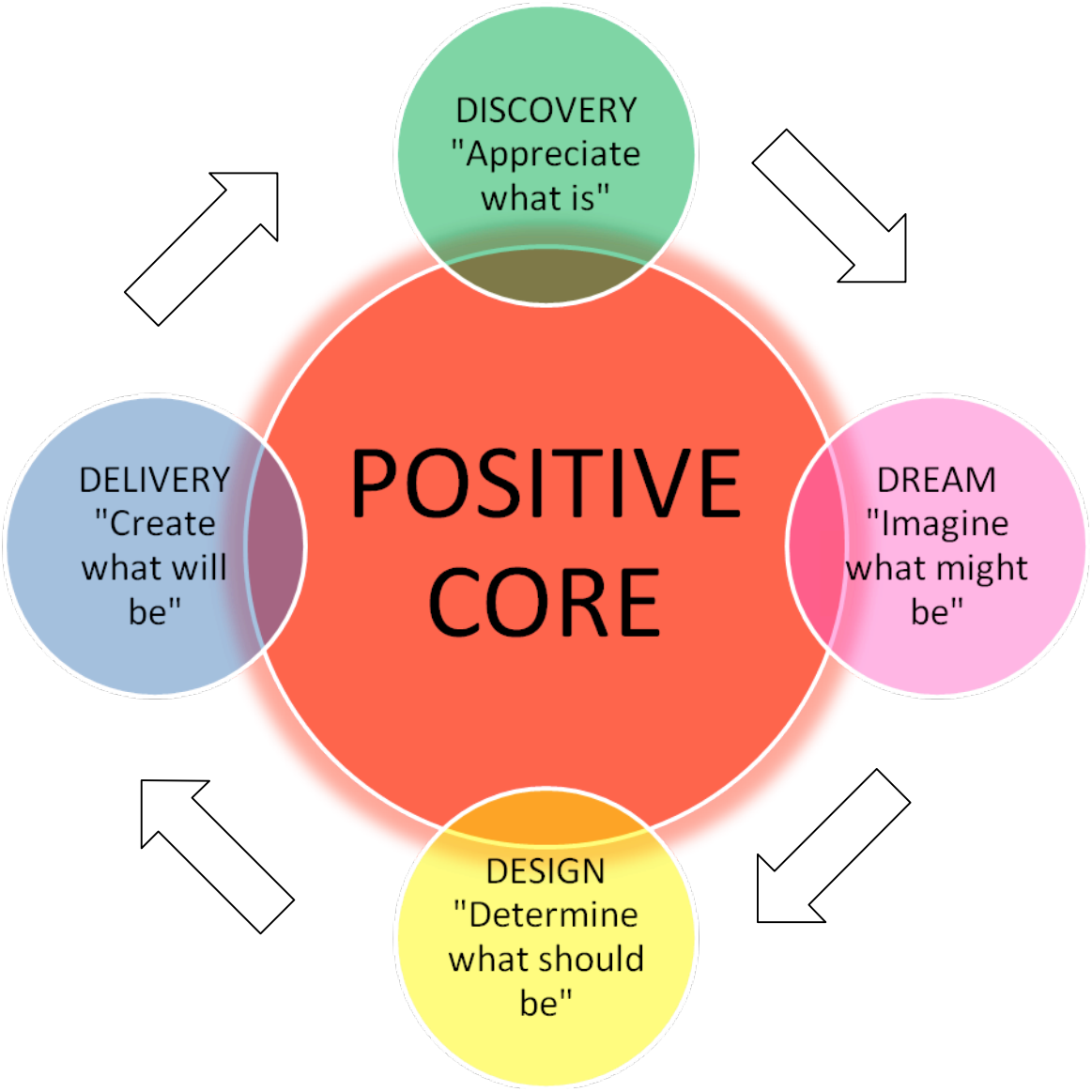

Figure 2.1 Diagram of Appreciative Inquiry 4-D cycle (Whitney & Trosten-Bloom, 2003:6)

Due to time constraints and the scope of this dissertation, I only facilitated the first two stages in the 4-D Cycle of Appreciative Inquiry, namely the discovery phase and the dream phase, to guide the inquiry process and to generate information. Reed (2007:124) provides examples of research that was done by concentrating on the first two stages of the 4-D cycle, namely the discovery and the dream phases, where an Appreciative Inquiry framework was used in conjunction with an organisational development programme. It is, however, possible to implement the latter stages of the 4-D cycle of design and delivery when doing research (Reed, 2007:124).

I felt that the discovery and dream phases could be linked to the assessment phase in the Theory for Health Promotion in Nursing, as both phases involve the collection of information, reflections on the past and deliberation relating to future action. The assessment phase in the Theory for Health Promotion in Nursing involves the collection and evaluation of information relevant to the internal and external environments, as well as the identification of facilitating and interfering factors (University of Johannesburg, 2009:8).

Although I only facilitated the first two phases of discovery and dream, I will discuss all four phases.

a) Discovery phase: "Appreciate what is"

The discovery phase is an all-embracing exploration to appreciate the best of the present situation, the life giving positive core. A positive core is the best of an organisation and its people (Cooperrider, et al. 2008:437). A positive core map is a visual representation of the resources, strengths and abilities of organisations (Cooperrider, et al. 2008:57).

Whitney and Trosten-Bloom (2003:7) suggest using one-on-one interviews in this phase. The one-on-one interviews involve face-to-face dialogue, usually conducted by organisational members after being trained in conducting appreciative interviews (Whitney & Trosten-Bloom, 2003:116). The one-on-one interviews comprise participants who interview each other in pairs using the provided interview schedule (addendum E).

The discovery process resulted in a detailed description of shared stories and serves to highlight collective organisational understanding. It also results in changes in the implementation of the following phases of the 4-D Cycle: the dream phase, the design phase and the delivery phase (Whitney & Trosten-Bloom, 2003:7-8).

In this phase Cooperrider (cited in Reed, 2007:35) suggests asking participants to describe a "peak experience" or "high point" regarding their experiences. A positive core can be expressed in various ways including narratives regarding achievements, best practices, competencies, assets, innovations, leadership capabilities, strategic opportunities, organisational achievements, organisational wisdom, positive emotions operational strengths, relationship resources, social capital, technical assets, values, vision, traditions, strength of stakeholders and capacities (Cooperrider, et al. 2008:35).

In the discovery phase, guided by the principles underlying Appreciative Inquiry as discussed under 1.6.2.2 (Whitney & Trosten-Bloom, 2003:8), I aimed to obtain a thick description of the positive core of the organisation (private mental health care setting).

I additionally drew a positive core map (addendum J) to ensure a thick description and to motivate participants to share narratives of their peak experiences relating to workplace support, in order to increase the combined understanding in the organisation relating to workplace support and to facilitate spontaneous transformation.

In the discovery phase the aim is to discover what provides energy to the individual or group. There is an assumption that there is energy and therefore I encouraged participants to discover this life-giving energy in their circumstances by carefully crafted questions. Cooperrider et al. (2008:103) express this phase as appreciating "the best of what is".

The request that was presented to all the participants for the completion of a naïve sketch is stated below:

- *Please write a story and tell me about a peak experience at work, when you felt most supported.*

The question that I asked participants (addendum E) in the discovery phase is stated below.

- *What actions from colleagues or supervisors makes you feel most supported at work?*

b) Dream phase: "Imagine what might be"

The dream phase is equally practical and creative. It accentuates the positive core and helps participants to imagine a constructive future of imagined results. In this phase

participants formulate their visions for the future. It is a joint exploration of dreams and possibilities (Whitney & Trosten-Bloom, 2003:8). Cooperrider (cited in Reed, 2007:36) suggests asking participants the following question: "what three wishes do you have for changing the organization?"

In the dream phase the facilitator motivates participants to dream unrestricted and innovative and to dream of possibilities that are immense and limitless and outside previous restrictions (Whitney & Trosten-Bloom, 2003:8). In the dream phase participants explore ideas of how the future could or might be. The dream phase develops from the first discovery phase. Cooperrider et al. (2008:103) express this phase as envisioning or "imagining what the world is calling for". In the dream phase the participants were encouraged to close their eyes and dream unrestricted.

My request (addendum E) to the participants in this phase is stated below:

- *Dream into the future and imagine this organisation giving you the best possible support at work.*

- *Please describe this dream.*

- *Please describe your wishes in order to realise your dream.*

c) Design phase: "Determine what should be"

In the design phase the participants construct future plans. This phase may include formulating provocative propositions or statements concerning what the individual or group still wants to aspire to, or objectives they still want to achieve. It is important to motivate participants to think in an assertive and positive way. Cooperrider et al. (2008:103) articulated this phase as co constructing or "determining the ideal".

d) Delivery phase: "Create what will be"

In the final or delivery phase energy progresses towards determining what is required to fulfil the provocative propositions. The researcher needs to motivate participants to reflect on detailed actions and processes, as well as to attain dedication from participants to deliver on their commitments. Cooperrider et al. (2008:103) define this phase as sustaining through

"empowerment, learning, adjusting and improvisation".

It is important to note that all the stages in the 4-D cycle are interconnected and that energy moves from one phase to the next in a circular movement. After completion of the delivery phase, the discovery phase and all the other follow-on phases can start all over again, as indicated in Figure 2.1 diagram of Appreciative Inquiry 4-D cycle.

2.4 RESEARCH METHODS

Polit and Beck (2008:758) describe research methods as the strategies and procedures of research. Reed (2007:112) suggests that there is a transformational focus from finding information in traditional research to generating or making information by applying Appreciative Inquiry. I will describe the research setting, the selection of participants, the data collection methods, the data analysis, measures to ensure trustworthiness and the ethical considerations of this research below.

2.4.1 Research setting and entrée

I conducted the research at a private mental health care setting in Gauteng. This mental health care setting has 150 beds with a short-term treatment programme. The majority of mental health care users admitted to the setting are diagnosed with mood disorders, eating disorders, substance abuse, personality disorders or anxiety disorders. The average period of treatment is two weeks and includes first-time admissions and readmissions. Since this is a short-term setting, some of the mental health care users are displaying acute psychiatric symptoms on admission, including loss of contact with reality and aggression.

There are seven wards with 18 to 24 beds in each ward. There is usually two to three staff members allocated to each ward, including one registered psychiatric nurse and one enrolled nurse. There is one care worker between one or two wards. The staff-to-patient ratio is between one to eight and one to 10, but Hanrahan et al. (2010:204) explains that there are "no empirical base" to establish the correct number of registered psychiatric nurses required for an inpatient psychiatric unit. Day staff members work on a fixed schedule of two to three days of 12 hours shifts with two days' rest in between, working every second Friday and every second weekend. Night staff members work seven nights of 12 hours each night, followed by seven days off duty.

There are currently 40 psychiatric nurses employed at this mental health care setting, as well as registered nurses (without psychiatry), enrolled nurses and care workers. These numbers include day and nigh personnel as well as members of middle and senior nursing management. Nursing management at this mental health care setting also uses nursing agency personnel on a daily basis. I did not include any agency personnel when I invited possible participants for this research, due to their irregular experience at this specific mental health care setting.

The functions of psychiatric nurses working at this setting include the administration of prescribed medication, the coordination of the daily programmes of clients, crisis intervention, nursing care activities, the formulation of nursing diagnosis and psychiatric nursing care for clients.

Psychiatric nurses participated in the data collection phase in their own time or during non-working hours in order not to disrupt the care of the mental health care users. Members of nursing management who participated in this research were all registered psychiatric nurses, one participant was at senior level and two participants were from middle nursing management. Senior nursing management refers to a psychiatric nurse who is involved with nursing service management, and middle nursing management refers to a psychiatric nurse who works with psychiatric nurses in the wards, performing administrative duties like audits of the files of mental health care users, performing in-service training and orientation and maintaining a supervisor position.

There are also other private agencies and individuals functioning in conjunction in order to provide client care, like psychiatrists, psychologists, occupational therapists, physiotherapists, cleaning agencies, catering services and gardening services. I previously worked in this setting for five years and is currently working at this specific mental health care setting on a temporary basis as a nursing agency member. I am known and well accustomed to the functioning of this organisation. I used this experience with the organisation to gain entrée, to invite participants and to formulate appropriate research questions. I will discuss the limitations regarding my prior engagement within this mental health care setting in paragraph 4.3.2.2 data collection method. Polit and Beck (2008:87) also suggest that the theme of the research should be in an area with which the researcher is familiar.

Before I conducted the research I contacted three gatekeepers, namely the Medical

Superintendent, Managing Director and the Nursing Service Manager of the private mental health care setting, in order to gain entrée (Polit & Beck, 2008:754). I had a preliminary meeting with the Nursing Service Manager to explain the research topic, the methods I proposed to use as well as a brief introduction to Appreciative Inquiry. I additionally provided the Nursing Service Manager with a copy of the proposal for my research, as well as examples of the information leaflet, consent form (addendum C) and the interview schedule (addendum E) I intended to use.

I also provided additional copies of the complete research proposal, with the information leaflet, consent form (addendum C) and interview schedule (addendum E), to the Medical Superintendent, the Managing Director and the Nursing Service Manager at this mental health care setting. The overall feeling at this meeting was very positive; however, the gatekeepers did have some questions later which resulted from the reading of my proposal. I responded to these questions by e-mail and still found the overall view from the gatekeepers to be positive. Questions focused on who I intended to invite to participate in the research, implications of data collection on client care and the process of data collection using an Appreciative Inquiry approach.

The Managing Director and the Nursing Service Manager were present at a second meeting I had with them in order to provide them with additional information regarding my proposed research and to answer any further questions that they had. I also needed to obtain written approval from the gatekeepers for my intended research at this meeting. I was amazed to find that, after my initial optimism, the gatekeepers harboured antagonistic feelings with regard to my research and that they were hesitant to grant me approval to continue with the research.

The gatekeepers at this setting verbalised that they felt positive about the theme of my research, but were hesitant regarding the response of their employees concerning the research, as well as the responses of participants during data collection. The gatekeepers were concerned that the research might influence the attitude of their employees negatively. Because the gatekeepers were unfamiliar with Appreciative Inquiry, I again briefly explained the methods to them, but left the meeting without written consent.

Reed (2007:121) provides some insight into possible reasons for gatekeepers to feel negative towards proposed Appreciative Inquiry research to be conducted. They might be apprehensive towards qualitative research due to their familiar ideas concerning quantitative

research requirements and results. Their previous experiences of research might have been negative as a result of being uninvolved or uninformed. Finally there might also have been disadvantageous consequences resulting from previous research, influencing participants or the organisation adversely.

My supervisors suggested another meeting with the Nursing Service Manager, during which it was agreed on that I would invite members of middle and senior nursing management to be individually interviewed by me, using the same interview schedule (addendum E) as for the core group inquiries. This corresponded clearly with what Reed (2007:70) suggested by arguing that invitations should be extended to as many participants as possible, including all the significant players in the organisation, in order to enhance acceptance, participation and to discover as many different views as possible.

The Nursing Service Manager of the mental health care setting where I did my research agreed to provide me with the necessary written consent (addendum B) after I have agreed to keep management informed about all the aspects of my research, including the invitation of participants, the data collection phases and the final findings.

2.4.2 Inclusion criteria for participants

I only invited participants who have been employed by the mental health care setting for at least six months prior to the research in order for them to have ample experience regarding workplace support in this specific setting. Participants must be registered psychiatric nurses in order to explore the specific experience and wishes of psychiatric nurses with regard to workplace support. Psychiatric nurses are also skilled in interview techniques, which were important during the one-on-one interviews that participants had with each other during the small core group inquiries. “Appreciative Inquiry interviews provide a vehicle that naturally draws on the interviewers’ skills” (Reed, 2007:115).

2.4.3 Selection of participants

I used purposeful sampling, which Polit and Beck (2007:763) define as a sampling method where participants are selected based on who will be the most informative regarding the topic of the research, namely workplace support in this research. The purpose of the research was to conduct an Appreciative Inquiry in order to generate an in-depth understanding of the experience and wishes of psychiatric nurses regarding workplace

support in a private mental health care setting. This search for substantial information regarding workplace support guided my selection and invitation of the participants.

All the participants in the research were registered psychiatric nurses, including participants who attended the small core group inquiries and members from nursing management with whom I conducted individual interviews.

Reed (2007:70) stresses that invitations to participants should be offered to all levels in the organisation in order to involve as many experiences as possible. I therefore invited members of nursing management who are registered psychiatric nurses to participate in individual interviews, as mentioned above, using the same interview schedule (addendum E) as for the small core group inquiry.

A small core group inquiry is a group that "conducts appreciative interviews" (Whitney & Trosten-Bloom, 2003:38-39). I felt that if members of nursing management were invited to participate in the small core group inquiries, it might lead to a feeling of uneasiness in participants and unwillingness to share information due to the presence of members from nursing management, or participants might have responded in a way that they felt members of management might approve of, influencing the credibility and authenticity of this research.

Members from the ethics committee also raised questions concerning the presence of middle and senior nursing management members at the small core group inquiries, and felt that it might influence the standard of information obtained during data collection. The data collection therefore involved the small core group inquiries and individual interviews with members from nursing management, which also enabled member checking and triangulation of the findings.

I am not aware of any coercion that formed part of the research; participation was voluntary in order to obtain authentic data of the experience and wishes of participants regarding workplace support.

Prior to the formal invitations to participate I focused on the building of rapport with potential participants. I previously worked in this setting for five years and I am currently working at this specific mental health care setting on a temporary basis as a nursing agency member, so this was achieved informally. (Please see 4.3.2.2, Data collection method, for possible limitations regarding my association with the participants.) Reed (2007:83) explained that if

the researcher is observed as being “part of the culture”, it can increase cooperation.

I obtained verbal consent from the nursing care manager to place an invitation to participate in my research in the tea room, since all potential participants were aware of my intended research. There were no reactions to this invitation.

Reed (2007:120) shared a description of the defence of participants of having no time to participate, thus explaining how some participants verbalise support for Appreciative Inquiry research, but do not contribute directly towards it in the end.

I continued to make personal invitations, where I gave information, explained confidentiality and answered questions. I provided willing participants with an information leaflet (addendum C) which I explained to them. I also used this opportunity to obtain written consent from each participant. Finally I asked the participants to complete the attached demographic information form (addendum D). The demographic information regarding the participants was significant with regard to the trustworthiness of the findings, as well as to describe the sample for possible repeat studies by other researchers. I treated all the personal information that could identify the participants as confidential, as will be further described in the paragraph 2.6, ethical considerations. Information obtained from the participants included their age, gender, race, psychiatric nursing experience and the period employed at the setting where the research took place.

2.4.4 Data collection methods

The data collection methods will be discussed in three parts, namely the naïve sketches, the small core group inquiries and the individual interviews with members of nursing management. The small core group inquiries included written answers on the interview schedule from the one-on-one interviews, transcribed feedback from the discussion phase, the positive core map, the nominal group technique, field notes and reflective interviews. See table 2.1 for a summary of the data collection and data analysis methods.

I used various types of data triangulation during the data collection, including naïve sketches, small core group inquiries, which included field notes, written answers on interview schedules, transcribed feedback from participants, positive core maps and information from the nominal group technique, and finally individual interviews with members of nursing management. Triangulation is defined by Polit and Beck (2008:768) as “the use of multiple

methods to collect and interpret data about a phenomenon, so as to converge on an accurate representation of reality". Data triangulation involves the use of multiple sources of data in order to validate the findings (Polit & Beck, 2008:543). Polit and Beck (2008:543) describe method triangulation as the use of "multiple methods of data collection about the same phenomenon". Method triangulation was achieved by inviting participants to complete the naïve sketches themselves, by participants conducting the one-on-one interviews with each other using the interview schedule (addendum E), by feedback from and discussion with participants, the results from the nominal group technique and by the individual interviews with members of nursing management. Time triangulation is data collection about the same phenomena at different times (Polit & Beck, 2008:543). Time triangulation was achieved by the completion of the naïve sketches before the core group inquiries, the two core group inquiries spaced approximately six weeks apart and by the final individual interviews with members of nursing management that stretched over the final month of the data collection. Person triangulation involves the collecting of data from different levels of individuals (Polit & Beck, 2008:543). Person triangulation was achieved by collecting data from psychiatric nurses as employees and from psychiatric nurses in managerial positions.

Table 2.1 Data Collection and Data Analysis Methods

DATA COLLECTION		
DISCOVERY PHASE		
Naïve sketch	Naïve sketch	Naïve sketch
SMALL CORE GROUP INQUIRY 1 (FOUR PARTICIPANTS)	**SMALL CORE GROUP INQUIRY 2 (THREE PARTICIPANTS)**	**INDIVIDUAL INTERVIEWS WITH NURSING MANAGEMENT (THREE PARTICIPANTS)**
Field notes	Field notes	Field notes
One-on-one interviews between participants (Discovery phase question)	One-on-one interviews between participants (Discovery phase question)	Individual interview (Discovery phase question)
Feedback from one-on-one interviews and group discussion	Feedback from one-on-one interviews and group discussion	
Positive core map	Positive core map	

DATA ANALYSIS		
Nominal group technique	Nominal group technique	
DREAM PHASE		
One-on-one interviews between participants (Dream phase question)	One-on-one interviews between participants (Dream phase question)	Individual interview (Dream phase question)
Feedback from one-on-one interviews and group discussion	Feedback from one-on-one interviews and group discussion	
Positive core map	Positive core map	
DATA ANALYSIS		
Nominal group technique	Nominal group technique	
Reflective interview with discussion leader	Reflective interview with discussion leader	
DATA ANALYSIS		
Open coding	Open coding	Open coding

2.4.4.1 Naïve sketches

A naïve sketch is notes or a short narrative by participants. Reed (2007:128) explains how Appreciative Inquiry studies sometimes invite participants to provide written accounts on the research subject, with the benefit of reflection time and the opportunity for participants to share their narratives in ways with which they feel comfortable. Reed (2007:128), however, cautions that participants might not engage or understand the research due to the absence of face-to-face interaction with the researcher. I explained the research and the naïve sketch to possible participants before obtaining written consent from them to participate in the research.

I also provided participants with my contact details in the participant information leaflet and consent form (addendum C) and encouraged participants to contact me if they had any questions regarding participation in the research or the completion of the naïve sketch.

The naïve sketches formed the first step in the data collection process, before the discovery phase question of the small core group inquiries, and were only completed by all the participants in this research. I requested all the participants to complete the naïve sketches in their own time, before the core group inquiries and before the individual interviews with members of nursing management.

The completion of the naïve sketches in the participant's own time had a dual function. Firstly the time frame of the data collection sessions was limited and secondly I did this in order for participants to conceptualise and reflect on the theme of workplace support without compromising the value of interaction with the researcher, since the naïve sketches were followed by either a core group inquiry or an individual interview. Participants would be invited to tell me in writing, in narrative form, about a peak experience at work when they felt most supported.

The request to facilitate the completion of the naïve sketch is stated below.

- *Please write a story and tell me about a peak experience at work, when you felt most supported.*

I collected the completed naïve sketches from participants before each small core group inquiry and before the individual interviews with members of nursing management. I provided an example of one completed naïve sketch in addendum K.

2.4.4.2 Small core group inquiries

Whitney and Trosten-Bloom (2003:38-39) define a small core group inquiry as a group that "conducts appreciative interviews" and suggest using a core group inquiry when working on a smaller scale, from five participants, and with time restraints. During the data collection phase of this research I facilitated two small core group inquiries on two different occasions consisting of four and three participants respectively.

The small core group inquiries were structured around one-on-one interviews which participants conducted with each other in groups of two, using an interview schedule (addendum E). Whitney and Trosten-Bloom (2003:116) further define one-on-one interviews as "face-to-face dialogue" or as a mutual process where two individuals interview each other consecutively, and it is usually conducted by members from the organisation.

I decided to implement two separate small core group inquiries in order to give all potential participants from all the different shifts equal opportunity to attend the data collection without interrupting the care to the mental health care users. I additionally conducted three individual interviews with members of middle and senior nursing management who were also psychiatric nurses and who met the inclusion criteria for participants as described in

paragraph 2.4.2.1.

The limited number of participants in the core group inquiries could be attributed to the fact that some participants who were invited were unwilling to take part in the research due to the fact that data collection occurred in their own time, some invited participants were not interested and some verbalised that they felt uneasy regarding the theme of the research. There were participants who were invited but were unable to attend the small core group inquiries on the arranged dates.

I was confident that data saturation was achieved despite the limited number of participants, since themes were repeated and no new information had been added to the data. The discussion leaders, my supervisors and the independent co-coder confirmed that data saturation has been achieved. Polit and Beck (2008:765) define saturation as "the collection of qualitative data to the point where a sense of closure is attained because new data yield redundant information". Conversation or dialogue, even between two members of the organisation, can be significant. Language is described as a design tool and dialogue as the process, with the purpose to express creativity and to realise dreams (Whitney & Trosten-Bloom, 2003:198).

Cooperrider et al. (2008:115) stress the importance of keeping to a planned time schedule. I prepared a complete time schedule (addendum F) for the core group inquiries beforehand and acted as the timekeeper during the two core group inquiries. Cooperrider et al. (2008:152) define the function of the timekeeper as the individual who ensures that the group sticks to the allocated time and who makes the discussion leader aware of the remaining time.

The data collection, which was structured as a small core group inquiry, took place at the specific private mental health care setting where psychiatric nurses were employed. The data collection phase lasted approximately four hours, including a tea break of 30 minutes.
It was a cold winter's morning when I went to the mental health care setting where I did the data collection. In the conference room I prepared the setting by organising seven chairs in two rows facing a white board. I also arranged two pairs of chairs in different corners of the room with clipboards, pens and the complete interview schedule for each of the four participants. I sat for a moment, carefully contemplating the day ahead, when the independent discussion leader arrived.

The discussion leader was an independent researcher on the first occasion and my supervisor on the second. The discussion leader ensures that each participant who wants to share their thoughts is heard and takes care that the group finishes in the allocated time frame (Cooperrider, et al. 2008:152). The function of the discussion leader, who acted independently and thus objectively, was twofold. The first was triangulation and the second was to facilitate the feedback from participants while I drew the positive core maps (addendum J) in order to ensure that all the emerging themes were identified and visible on a white board before the implementation of the nominal group technique.

The discussion leader and I had an interview to clarify each other's expectations for the day. My expectation of the discussion leader was that she would use communication techniques to obtain descriptions of the experiences and wishes of participants regarding workplace support when they gave feedback during the discussion phase of the data collection. I also expected her to substantiate the information and identified themes with the participants.

The discussion leader also facilitated the nominal group technique to confirm and categorise identified themes according to priority. Strydom (2005:419) suggest the use of the nominal group technique in a group with less than 10 members in order to prioritise the opinions of people regarding a challenge. The facilitation of the nominal group technique served a dual function, namely as a way of performing member checking and as a data analysis technique by identifying themes that were important for the participants. Polit and Beck (2008:758) describe member checking as a validating method employed through discussions with participants in order to assess the accuracy of the data collected.

Participants started arriving, looking a bit apprehensive, which I attributed to my own anxiety on the one hand and to the new situation on the other. Participation always demands time and energy from participants, which could make them feel hesitant to participate (Reed, 2007:21). It was this uncertainty of what to expect or what amount of effort I would expect from them that could have made participants apprehensive. This could possibly been alleviated if I had given participants more information regarding the purpose and the structure of the data collection during the invitation phase.

During the first core group inquiry we started an informal discussion while waiting for the other participants to arrive, and soon the formal prearranged seating naturally changed into an informal circle. The discussion leader suggested that we leave the chairs in this circle since it is a significant part of the interaction process. At the second inquiry I arranged the

chairs in a circle from the start. Two participants arrived late at the first inquiry and one participant who had given consent did not arrive at all during the second inquiry, which left me feeling agitated. Reed (2007:121) cautions that the researcher should expect reluctance from participants.

I formally started the relationship phase of the small core group inquiry with introductions. I explained the purpose of the small core group inquiry to the participants, namely to collect data concerning their experiences and wishes relating to workplace support. I elaborated but did not actually define workplace support. I wanted the personal views of the participants regarding workplace support, and also wanted to motivate participants to explore a wide range of experiences relating to what they experienced as being supportive in their workplace.

I encouraged participants to reflect on their experiences regarding workplace support. I also explained the purpose of the research to the participants in terms of exploring their experiences and wishes regarding workplace support and proposing recommendations in order to promote their mental health. I emphasised that this research was also being conducted to empower psychiatric nurses by giving them an opportunity to be heard, by voicing their needs of support, as well as to dream and to verbalise their wishes regarding workplace support. A core group inquiry "establishes a base of enthusiasm" (Whitney & Trosten-Bloom, 2003:40).

I additionally explained my selection criteria to the participants, namely that they were psychiatric nurses experienced in receiving and giving workplace support in this specific setting and that they are also skilled in interview and communication techniques, all of which was needed for this specific method of data collection. I confirmed that I would make a copy of the final research findings available to management at this mental health care setting, as well as to the participants.

I shortly clarified the ethical considerations concerning this research. I confirmed that I had received written consent from the ethics committee of the University of Pretoria (addendum A), as well as written consent from all the relevant gatekeepers at this mental health care setting (addendum B). I explained confidentiality to the participants, but stated that although confidentiality is guaranteed outside the data collection sessions, it is difficult in a group setting. I requested participants to treat the information obtained during the small core group inquiries as confidential. According to Polit and Beck (2008:181), it is difficult to assure

anonymity in qualitative research due to the researchers' involvement with the participants. The participants did sign consent for the use of a digital voice recorder, but I again emphasised that I would be using a digital voice recorder during the feedback phase of the data collection in order to capture all the responses of the participants.

I conveyed to the participants that I had the idea to do research on workplace support, but found that there were already very effective mechanisms and systems in place to provide workplace support to psychiatric nurses employed at this mental health care setting. This became evident in the discovery phase when participants shared their narratives about their own peak experiences regarding workplace support.

I told participants how one of my supervisors introduced me to Appreciative Inquiry. This gave me the opportunity to view my research in a completely different light. I could now explore the peak experiences of psychiatric nurses regarding workplace support, making recommendations based on their wishes and what they experienced as being supportive. My research was thus aimed at exploring "what the situation entails" (Reed, 2007:VIII) and I encouraged them to share any information that they felt comfortable with.

I explained that Appreciative Inquiry was a form of transformational inquiry that selectively seeks to highlight the life-giving forces in an organisation and that systems are imagined and formed by those working in the organisation (Cooperrider, et al. 2008:XI).

I continued to define Appreciative Inquiry for the participants in terms of the meaning of the concept "appreciate", which is to assess and encourage the best in people, as well as the concept "inquiry", which is to explore new possibilities through purposeful and transformational questioning (Cooperrider, et al. 2008:1). I clarified the four phases of Appreciative Inquiry for the participants, namely discovery, dream, design and destiny, by comparing the phases to the nursing process, which was well known to psychiatric nurses participating. I mentioned that we were only going to implement the first two phases, namely that of discovery and dream, during the core group inquiry.

In order to clarify Appreciative Inquiry further for the participants, I highlighted a few assumptions of Appreciative Inquiry, namely the constructionist principle, the simultaneity principle, the anticipatory principle, the positive principle and the enactment principle (Whitney & Trosten-Bloom, 2003:54-55). To close my introduction and in order for the participants to conduct their one-on-one interviews with each other, I summarised some

interview and communication techniques which were already well known to psychiatric nurses participating. I briefly discussed paraphrasing, questioning, interpretation and summarising (Johnson, 2006:133).

Data collection during the small core group inquiries will be discussed under field notes, written answers on the interview schedule (addendum E), transcribed feedback from participants, positive core maps (addendum J), the nominal group technique and transcriptions from reflective interviews.

a) Field notes

Greeff (2005:298) describe field notes as a written description of what the researcher saw, heard and experienced during data collection. Field notes include the seating arrangements and the order in which participants speak in order to help in voice recognition during transcribing as well as the non-verbal behaviour of the participants (Greeff, 2005:311).

These observational field notes were supplemented by reflective field notes, including methodological notes, theoretical notes and personal notes. Polit and Beck (2008:406-407) define observational field notes as an objective description of events, reflective notes as reflections regarding the methods used, theoretical notes as reflections on "how to make sense" and personal notes as reflections on the feelings of the researcher.

During the first inquiry an independent discussion leader and my supervisor were present. They took continuous field notes of the proceedings. During the second inquiry my supervisor acted as the discussion leader and I took the field notes.

I was present at all times to observe the one-on-one interviews that participants conducted with each other, to make field notes and to answer the questions of participants regarding data collection, thus being in the field to witness the actions of the participants (Stake, 1995:8-9).

My theoretical field notes focused on the identified themes and the nominal group technique. Personal field notes included my awareness of the feeling of the participants after the discovery and the dream phases, as well as notes on my personal identification with the participants.

b) Written answers from one-on-one interviews

I resumed by clarifying the agenda of the day for the participants. I explained how pairs of two participants were going to conduct the one-on-one interviews with each other for 15 minutes, using the provided interview schedule (addendum E). I described how participants will be invited to give feedback on their answers as a group, followed by a discussion of the themes. This process would be repeated for the dream phase after the tea break. I read and explained the first question of the discovery phase to the participants. I checked whether participants had any questions before they began their interviews.

I allowed participants to divide into two groups according to their personal preferences. I provided each participant with an interview schedule (addendum E), a clipboard and a pen. I acted as group facilitator by selecting the questions contained in the interview schedule (Cooperrider, et al. 2008:131). During the first core group inquiry the four participants divided into two groups and during the second core group inquiry participants conducted their interviews in a group of three participants. During the one-on-one interviews that participants conducted in pairs I acted as timekeeper and observer while making field notes and answering questions from participants.

The interview schedule contained questions based on the first two phases of the 4-D cycle of Appreciative Inquiry, namely the discovery phase and the dream phase. Prior to these questions a lead-in statement was presented to the participants. A lead-in serves as an introduction to the affirmative topic, creating the tone for the inquiry and helping participants to reflect on the topic (Whitney & Trosten-Bloom, 2003:150). The lead-in statement is stated below.

- *When our organisation is functioning at its best, it offers diverse methods of workplace support to us.*

This lead-in statement was followed by the first question. The discovery phase question is stated below.

- *What actions from colleagues or supervisors makes you feel most supported at work?*

Participants interviewed each other one-on-one for approximately 30 minutes in accordance with the interview schedule (addendum E). Participants wrote down the answers to the

questions on the interview schedule during their interviews.

It was interesting to note that during the one-on-one interviews that participants conducted with each other, the dynamics shifted from an initial meticulous following of the interview schedule and interviewing to a lively discussion and interaction between participants.

I ensured that participants had sufficient time to complete their interviews by checking on each pair and asking them whether the time was sufficient and whether they completed their interviews, while still keeping to the time schedule (addendum F). Participants then returned to the circle of chairs to give their feedback, using their completed interview schedules.

c) Transcribed feedback

Participants from the first core group inquiry were initially unsure how to proceed and the discussion leader replied that they can share in any way that made them feel comfortable. The first participant started to read her answers from the interviews, but soon that also changed into a lively discussion with all the participants contributing.

A short discussion of the identified themes followed in order for the discussion leader to clarify information with the group members. The discussion leader verified the content as well as her understanding of the information and themes by using communication skills like paraphrasing, reflecting, clarifying and summarising (Okun & Kantrowitz, 2008:75-76). The discussion leader would repeat a comment from a participant or an identified theme in order to check the accuracy or summarise information after some discussion among the participants. The discussion leader would also ask participants to elaborate or explain some detail during the feedback if some comment seemed vague or unclear.

I recorded the feedback, with the permission of the participants, commentary on the themes and the resulting discussion of the themes on a digital voice recorder. I later personally transcribed these recordings.

d) Positive core map

The discussion leader, in conjunction with the group, obtained consensus and identified emerging themes during the feedback. I functioned as the recorder, putting all the themes, as they emerged from the feedback of the participants, in writing on a whiteboard as a

positive core map (addendum J) for all the group members to see. Cooperrider et al. (2008:259) define the role of the recorder as the individual who writes the output of the participants on a chart. A positive core map is a visual illustration or summary of the resources, strengths and possibilities of the organisation (Cooperrider, et al. 2008:57). Whitney and Trosten-Bloom (2003:116) describe this as the most frequently used approach in Appreciative Inquiry.

Cooperrider et al. (2008:111) suggests that collecting illustrations of the positive core map is meaningful, which inspired me to take a photograph of each positive core map that was drawn and included in the data collected. I also included two photographs as examples of the positive core maps as addendum J.

e) Nominal group technique

The nominal group technique is a technique for a small group which involves the prioritising of needs or problems of a community (Strydom, 2005:419). In this research the nominal group technique was facilitated during the small core group inquiries, after each discovery phase discussion and again after each dream phase discussion, in order to prioritise the themes that were identified during the discussion phases.

After all the participants had shared their stories, the discussion leader summarised the identified themes on the positive core map. The nominal group technique was then facilitated where participants had the opportunity to make their choices regarding the five most important themes to them personally. The participants carried out the nominal group technique by putting up five stickers next to the five themes that they experienced as being the most important to them.

The implementation of the nominal group technique also served as member checking due to the fact that my interpretation of the information and identification of the emerging themes while drawing the positive core map were verified by participants by means of the performance of the nominal group technique.

During both core group inquiries the overall feelings of the participants at that stage of the process were very positive. Some participants stated that the questions regarding peak experiences from the naïve sketches and the discovery phase question regarding supportive actions from supervisors and colleagues, as well as the resulting discussion, made them

realise just how fortunate they were to work at that specific mental health care setting. This overall positive mood confirmed what Reed (2007:VIII) wrote about Appreciative Inquiry as being transformational.

While refreshments were served we discovered that during the first core group the participants had already completed their interviews for the dream phase as well. This could be ascribed to the fact that I provided participants with the complete interview schedule from the start and did not clarify the process clearly. I ensured that participants did not discuss both the discovery phase and the dream phase questions at the same time during the second core group by clearly explaining the process.

During the dream phase the discussion leader encouraged participants to close their eyes and dream into the future, wave an imagery magic wand and imagining that they experienced the best possible support at work.

The dream phase was facilitated by the inquiry statements below.

- *Dream into the future and imagine this organisation giving you the best possible support at work.*

- *Please describe this dream.*

- *Please describe your wishes in order to realise your dream.*

The participants gave feedback from their dream phase interviews in the same manner as during the discovery phase. The discussion leader facilitated the feedback while I recorded the emerging themes as a positive core map (addendum J). A discussion followed about the identified themes in this phase and the group again performed the nominal group technique in order to prioritise the main themes.

The overall feelings of the participants were still positive, but not comparable to their feelings after the discovery phase. Participants might have been tired at this point in time or the dream phase might have illuminated their dreams or wishes regarding workplace support, leaving them with a sense of apprehension. This uneasiness could have been the result of a feeling of being unfulfilled due to the fact that I only implemented the first two stages of discovery and dream.

I conducted the termination phase by evaluating whether the participants had any further questions. When the participants were asked how they experienced the morning, they all confirmed that it was positive to be reminded of all the things that were already supportive towards psychiatric nurses in this environment. They also verbalised that they felt as if they had a voice and would like to engage in small core group inquiries more often.

I reminded participants that I might refer back to them for member checking at a later stage. I also made myself available afterwards if participants needed support or referrals due to the sharing of information that caused them discomfort, like past experiences that made them feel less supported at work. No participant verbalised a need for support or contacted me after the data collection in order to verbalise their need for support.

f) Reflective interview

After the completion of each small core group inquiry the discussion leader conducted a reflective or debriefing interview with me, in order for me to formulate some additional reflective notes concerning the process of inquiry, the data obtained or the identified themes and the ethical considerations of the research. Reflective notes or field notes ought to include notes on the data collection methods used, the analytical aspects of the research and personal notes relating to the experiences or observations of the researcher during data collection (Polit & Beck, 2008:406-407).

Moderator debriefing is described as one of five types of debriefing and is aimed at identifying the initial perceptions of the researcher, unexpected findings, noteworthy statements by participants and to assess whether data saturation was achieved (Onwuegbuzie, Leech & Collins, 2008:5).

I felt that I had already achieved data saturation at this point after the two core group inquiry sessions, since many of the identified themes overlapped, and I was confident that possible unidentified themes did not warrant another core group inquiry. The discussion leaders confirmed that data saturation was achieved after the two small core group inquiries. The independent co-coder and my supervisors additionally confirmed data saturation. Polit and Beck (2008:765) define data saturation as the collection of data in qualitative research until no new information or themes emerges or until the impression of the researcher is that of closure. I still needed to conduct individual interviews with members of nursing management in order to hear as many different voices as possible relating experiences and wishes

regarding workplace support and to triangulate the findings.

I found the reflective interviews significant in relation to my own reflection regarding the ethical aspects, data saturation, the nominal group technique and the Appreciative Inquiry process.

2.4.4.3 Individual interviews with members of nursing management

After I had completed the two small core group inquiries, I invited members of middle and senior nursing management who were registered psychiatric nurses to be individually interviewed by me. I identified three willing participants and after I had given them a short description of the data collection process, I provided them with a consent form (addendum C), a demographic form (addendum D) and a naïve sketch to complete in their own time.

The completion of the naïve sketches beforehand would provide them with time to reflect on their experiences and wishes regarding workplace support before I conducted the interviews with them.

I conducted one interview at a private venue and the other two interviews at the private mental health care setting where I did my research. The interviews lasted between 30 and 45 minutes each.

I used the same inquiry statements (reflected in the interview schedule, addendum E) that I prepared and used in the small core group inquiries to facilitate the individual interviews, as stated below:

- *Please write a story and tell me about a peak experience at work, when you felt most supported.*

- *When our organisation is functioning at its best, it offers diverse methods of workplace support for us.*

- *What actions from colleagues or supervisors make you feel most supported at work?*

- *Dream into the future and imagine this organisation giving you the best possible support at work.*

- *Please describe this dream.*

- *Please describe your wishes in order to realise your dream.*

I made field notes during the interviews and recorded the interviews on a digital voice recorder, with written permission from the participants, which I personally transcribed at a later stage.

I found the individual interviews with members of nursing management to be more complex. These individuals from nursing management were expected to be the support givers to psychiatric nurses employed by them. Information from the individual interviews with members of nursing management correlated with that from the core groups, but focused more on the support received from colleagues who were also in nursing management positions.

Participants from the small core group inquiries verbalised that they experienced their fellow psychiatric nurses, as well as members from nursing management, to be supportive. Participants from the small core group inquiries focused more on the effectiveness of systems, which was not so evident during the interviews with nursing management. The individual interviews did, however, provide me with insight into the experiences and wishes regarding workplace support from the point of view of the nursing managers.

2.4.4.4 Role of the researcher

The character of the relationship between me and the participants was crucial to both the data collection and the data interpretation phases of this research. It was therefore important to me to have the assistance and support of the participants (Burns & Grové, 2007:76). Burns and Grové (2007:77) continue to describe the interactive influence of the researcher and the participants, which is an expected aspect in the qualitative research process and important for my understanding and interpretation of their described experiences.

Henning, Van Rensburg and Smit (2004:81) illustrate how the researcher "becomes the instrument of observation" by integrating that which is heard, seen, sensed or read into a translation of that which is present in the environment of the researcher. I also analysed the data more than once (Henning, et al. 2004:82); firstly by observation during data collection

and field notes, as well as by facilitating the nominal group technique, and secondly by performing open coding by referring to the written transcriptions of feedback and photographs of the positive core maps (addendum J).

In the discovery phase I formulated the interview questions, the interview schedule and the interview plan and inquiry strategy. I also coached participants to conduct Appreciative Inquiry interviews and share narratives of best practices (Whitney & Trosten-Bloom, 2003:149).

I needed to decide which participants would be a rich source of information in the discovery and dream phases and I assured that the voice of every participant was heard. I also needed to decide what the outcome of the discovery and dream phases had to be and how participants would reveal or share their particular dreams (Whitney & Trosten-Bloom, 2003:183).

2.4.5 Data analysis method

During the data analysis phase I used two different techniques in order to analyse the available data. The reason for the use of two different techniques was firstly due to the two different ways of data collection that occurred and secondly to achieve analysis triangulation, which is achieved by using two analytical techniques on the same data (Polit & Beck, 2008:548). See paragraph 2.4.3, table 2.1, data collection and data analysis methods.

The available data consisted of the written naïve sketches of all the participants, written answers on the interview schedules from the one-on-one interviews during the small core group inquiries, transcriptions of recorded data from feedback of the participants during the discussion phases of the small core group inquiries, photographs of the positive core maps that indicate the nominal group technique which were drawn by me in conjunction with the participants, field notes taken by my supervisor and myself during the core group inquiries, transcribed voice recordings from the debriefing or reflective interviews with the various discussion leaders after the core group inquiries, as well as transcriptions and written answers from the individual interviews with members of nursing management.

Data analysis already began with the identification of themes and the positive core map that I drew during the data collection phase. The facilitation of the nominal group technique during the core group inquiries also assisted in the identifying and conformation of themes

by the participants. After the two small core group inquiries I sorted and categorised the identified themes recorded on the positive core maps according to the preference of the participants, as indicated during the nominal group technique.

I used the technique described by Tesch (1990:142), namely an inductive, descriptive approach to data analysis. I used open coding to sort and categorise themes from the transcriptions of the discussion phase and the individual interviews. Polit and Beck (2008:760) define open coding as a description of the themes from narrative data. After personally transcribing the voice recordings from the two core group inquiries and the three individual interviews, I read through the data while reflecting on and noting clusters of themes in order to discover an overview of the content.

I organised the data manually by using highlighter pens in different colours. I made a list of all the themes, including those from the nominal group techniques, and arranged the themes into categories after naming each theme and coding each topic or theme with an explanatory sentence. I compared and noted interrelationships between themes, recoding some themes as I analysed them.

In keeping with the symbol of the thorn tree (discussed later under the central storyline in paragraph 3.3.1) I described the themes as branches and the categories as leaves and buds. The categories described as leaves emerged during the discovery phase questions and the categories described as buds emerged during the dream phase questions of the small core group inquiries and the interviews and it resembled the wishes of psychiatric nurses regarding workplace support.

I gave copies of these categories, along with the transcriptions of the recorded data and positive core maps, to an independent co-coder for verification of the identified themes. I also provided the independent co-coder with a work protocol (addendum I) to ensure that the same method of inductive, descriptive design to data analysis was used. Polit and Beck (2008:551) stress the importance of verification of data and the analysis process by thoroughly confirming and checking the data and the analysis thereof. I had a discussion with the co-coder where consensus was reached with regard to the identified themes. This process also ensured analysis triangulation, which involves the validation of the meaning of qualitative data (Polit & Beck, 2008:548).

After the independent co-coder has confirmed the themes that were identified, she

suggested that it fits perfectly in the Theory for Health Promotion in Nursing. I went back to all the data and categorised the confirmed themes again according to the internal and external environments as defined by the Theory for Health Promotion in Nursing. Since it is difficult for a qualitative researcher to describe the inductive process used to come to a conclusion (Polit & Beck, 2008:530), I provided some examples of the original data in chapter 3 to support my findings. Finally, I conducted a literature control, integrated into chapter 3.

2.5 METHODS TO ENSURE TRUSTWORTHINESS

I used the standards described by Lincoln and Guba (cited in Polit & Beck, 2008:539-540) as criteria to ensure trustworthiness in this research, namely credibility, dependability, confirmability, transferability and authenticity.

2.5.1 Credibility

Credibility is to validate that the investigation was performed in such a way as to describe the concept of workplace support accurately and sufficiently (De Vos, 2005:346). The credibility of the research was enhanced by using more than one data source, namely the naïve sketches, the written answers from the one-on-one interviews of the participant, field notes, the transcriptions of the feedback in the group phase, photographs of the positive core maps (addendum J) and transcriptions of the individual interviews with members of nursing management.

The participants were all registered psychiatric nurses, competent in interview and communication skills. Interview schedules (addendum E) were provided to guide participants through the interviews. I conducted a brief introduction to Appreciative Inquiry and interview techniques during the small core group inquiries. I gave participants sufficient time to complete their one-on-one interviews during the small core group inquiries and afforded them an opportunity to add information during the group discussions of the small core group inquiries. I made field notes during the interviews and while participants reported back on their interviews, noting any additional information.

Investigator triangulation is the use of more than one researcher to enhance validity (Polit & Beck, 2008:756). Investigator triangulation was achieved by the inherent method of Appreciative Inquiry used, namely the one-on-one interviews and the presence of a

discussion leader. Data collection also occurred on two different occasions, namely the small core group inquiries and the individual interviews with members of nursing management, which resulted in data triangulation. Triangulation was finally used in the analysis stage by means of the presence of a co-coder who verified the findings of the identified themes (Polit & Beck, 2008:543).

I used two different types of data analysis, namely the nominal group technique and open coding in identifying the themes. I used member checking by the performance of the nominal group technique, after each group discussion of the small core group inquiries, in order to enhance the credibility of the research. Participants were each given the opportunity to identify the five most important themes to them personally.

Researcher credibility reflects on the researcher as the data collection instrument and the producer of the data analysis process, thus emphasising researcher qualifications, reflexivity and experience (Polit & Beck, 2008:550). I completed a research methodology programme prior to conducting this research. Both supervisors of this research hold a Doctoral degree and have extensive experience in nursing research. The researcher is a psychiatric nurse, skilled in reflection-in-action, as well as reflection-on-action (Brown, Esdaile & Ryan, 2004:121). Reflective thinking is the careful consideration of any supposed form of knowledge (Brown, et al. 2004:122). I was aware of my own reflective activities during all the stages of the research. I kept field notes to capture additional information and personal reflections on emerging themes and the processes that transpired.

2.5.2 Dependability

Polit and Beck (2008:751) define dependability as the criterion for the evaluation of the integrity of qualitative research, referring to the stability of the data over conditions and time. I ensured the dependability of this research by describing and documenting all the phases and methods used in the research comprehensively and by making all documents available for an audit trail if required. All transcriptions and documents will be kept in the Nursing Department for 15 years. I also provided an example of a completed naïve sketch (addendum K), as well as photographs of two positive core maps (addendum J).

The variation in the themes from the small core group inquiries and the themes from the individual interviews with managers might be ascribed to the fact that psychiatric nurses from the small core groups viewed themselves as the support recipients while members of

management were seen as the support givers.

2.5.3 Confirmability

Polit and Beck (2008:750) define confirmability as the criterion for the evaluation of integrity in qualitative research, referring to the neutrality or objectivity of the collected data and the interpretation thereof. Polit and Beck (2008:539) continue to describe this objectivity as the "potential for congruence between two or more independent people" regarding the accuracy, meaning and relevance of the data.

I will discuss the quality enhancement strategies relating to confirmability that were used in this research according to Polit and Beck (2008:544). I used various methods of triangulation, as discussed under credibility, in order to achieve the confirmability of this research, including investigator triangulation, method triangulation, data triangulation, time triangulation and analysis triangulation. I described the steps used in the research process, including the data collection and analysis methods used in this research. I used an independent co-coder to verify the findings. I also conducted a literature control to verify the findings and provided examples of the original data collected in order to represent the voices of the participants. All documentation relevant to this research will be kept in the Nursing Department for 15 years and will be available for an inquiry audit if required.

2.5.4 Transferability

Transferability means the applicability of the findings from one research to other circumstances (De Vos, 2005:347). Although transferability was not my aim due to the contextual design I used, I did indicate selected transferability of the research by ensuring a dense description of the data and by giving examples of the original data in chapter 3. During the sampling phase, which was purposeful sampling, I aimed to invite participants who were a possible rich source of information. Finally, I performed a literature control in chapter 4 in order to recontextualise the findings of the research in existing literature and to clarify the inference made.

2.5.5 Authenticity

Authenticity is defined by Polit and Beck (2008:748) as the extent to which an impartial qualitative researcher demonstrated a wide range of experiences in the data and analysis. I

was familiar with the mental health care setting where the research took place, which added to the authenticity of the research. The nature of the Appreciative Inquiry method used, namely starting with the naïve sketches, followed by the one-on-one interviews, which led to feedback and a discussion, before drawing a positive core map, all contributed to my comprehension of the data and the authenticity of the final findings.

The use of communication techniques like summarising and questioning by the discussion leader, facilitation of member checking or the nominal group technique and the additional individual interviews with members of management, all contributed to the authenticity of my research. I provided examples of the naïve sketches and verbatim transcriptions of the small core group inquiries and the individual interviews with members of nursing management, as well as examples of the positive core maps, in order to represent the voices of the participants in this research and to reflect on the reality of participants.

2.6 ETHICAL CONSIDERATIONS

Prior to conducting the research, I referred to the ethical principles for medical research involving human subjects of the World Medical Association Declaration of Helsinki (University of Pretoria, 2005) for guidance with regard to the ethical implications of the research. According to the Declaration of Helsinki, the researcher must demonstrate compliance with the ethical considerations.

I discussed the ethical considerations relevant to this research as described by Burkhardt and Nathaniel (2002), namely autonomy, beneficence, non-maleficence, veracity, confidentiality, justice and fidelity.

2.6.1 Autonomy

According to Burkhardt and Nathaniel (2002:41-42), autonomy means that individuals must be free to make choices with regard to issues in their own lives. This means that I showed respect for the participants, their personal goals, their dreams and their proposed plans during the data collection phase of the research. Participants in this research participated voluntarily and I allowed participants to divide themselves into pairs for the one-on-one interviews during the small core group inquiries in order to put them more at ease and to show respect for their autonomy.

The researcher demonstrated respect for participants and for the organisation as a system by obtaining informed and voluntary consent from the Managing Director of the mental health care setting (addendum B), as well as all participants involved in the research (addendum C). The participants had the option to withdraw from the research at any time if they required to, and no intentional coercion was used. Polit and Beck (2008:172) define coercion as threats of negative or positive consequences for participating in the research or for sharing information. The free-choice principle of Appreciative Inquiry also acknowledges the benefit of giving people autonomy.

2.6.2 Beneficence

Polit and Beck (2008:748) define beneficence as research that avoids harm to the participants and aims to increase the benefits that are offered to participants. Participants have the right to be free from harm and the right to be protected from exploitation (Polit & Beck, 2008:170-171).

The risks of research are justified by the potential benefits to the individual or the society, or the mental health care setting in this research. I made myself available to the participants for intervention or referrals after the core group inquiries if they felt the need for support after the data collection.

Possible risks and discomfort of this research could have been that some of the questions asked might have made the participants feel uncomfortable, but participants were informed that they need not share information if they did not want to. I was able to evaluate the impact of the data collection phase on participants during the feedback phase of the small core group inquiries. Possible negative effects might have included the sharing of negative experiences from the past and the emotions stemming from those experiences. Participants were also expected to travel to the venue once and to participate in their own time, approximately four hours, without compensation.

Possible benefits of this research included that participants might benefit directly by participating in the data collection phase because of the Appreciative Inquiry method used, which can be supportive in nature and can enhance collaboration of psychiatric nurse practitioners and management. The results of the research can enable better workplace support to psychiatric nurses in future by means of recommendations made with regard to organisational policy.

Liamputtong and Ezzy (2005:42) point out that owing to the narrative nature of qualitative methods, research can be inherently therapeutic. The small core group inquiry was therapeutic in itself by giving participants the opportunity to verbalise their experiences and wishes regarding workplace support. The mental health care setting at which the research took place can also benefit through the possible implementation of recommendations from the research, leading to a possible decline in absenteeism and personnel turnover.

The results of this research regarding workplace support in a private mental health care setting would be made available to all the participants and members of management on request.

2.6.3 Non-maleficence

Non-maleficence in this research meant not causing harm to the participants or the mental health care setting in any way (Burkhardt & Nathaniel, 2002:51). I obtained ethical approval from the Ethics Committee of the University of Pretoria before conducting the research (addendum A). I also obtained written consent from the management of the mental health care setting where the research took place, including from the managing director, the Nursing Service Manager and the medical superintendent (addendum B). I provided all participants with an information leaflet and consent form (addendum C) prior to the data collection phase. All the participants signed these consent forms before the data collection phase commenced.

Possible negative effects could result from the sharing of past negative experiences and the emotions associated with those experiences. I was able to evaluate the impact of the data collection phases on the participants during the feedback phase of the core group inquiries and during the individual interviews with members of management. I was also available for intervention or referrals after the small core group inquiries if participants needed counselling. Participants were made aware of my availability for intervention through the information leaflet that was handed to them prior to signing consent to participate in the research (addendum C). I am a psychiatric nurse who is able to evaluate and intervene, or alternatively refer participants, should any unwanted effects from the research be perceived.

The revealing of less effective ways of providing workplace support in the past by members of management from the mental health care setting may cause possible harm to the organisation. This can be overcome in the dream phase where participants suggest

alternative means of facilitating workplace support. I worked from a positive framework in referring to experiences by using the method of Appreciative Inquiry.

2.6.4 Veracity

I was honest regarding the subject, purpose, methods and results of the research when gaining entrée, obtaining consent from managers (addendum B) and participants (addendum C), as well as when communicating the results and the limitations of the research (Burkhardt & Nathaniel, 2002:51). The data collection phases included small core group inquiries where all participants could witness the discussion phases and information given.

2.6.5 Confidentiality

Polit and Beck (2008:750) state that confidentiality means that I protected the participants as well as the mental health care setting by signing an agreement to keep personal identifying information, as well as data linked to a specific participant, confidential. Although confidentiality is guaranteed outside the data collection sessions, it is difficult in a group setting. Participants were made aware of the data collection method and confidentiality before signing consent to participate through the information leaflet (addendum C). According to Polit and Beck (2008:181), “anonymity is almost never possible in qualitative studies”.

I gave participants the opportunity to divide themselves into groups to make them feel more at ease during the interviews. The only other parties that had access to the data or discussions about the research were my supervisors, the discussion leaders of the small core group inquiries and the co-coder. I signed confidentiality agreements with the discussion leader (addendum G), who also acted as the co-coder (addendum H).

Primary data, as well as documentation resulting from coding and analysis, will be kept under lock and key for 15 years in the Nursing Department.

2.6.6 Justice

Polit and Beck (2008:173) define justice as the reasonable and non-discriminatory treatment of participants as well as respect for their right to privacy. Although the demographics of this

research give the impression of bias due to the limitation in representation regarding sex and race, I invited all potential participants who fell in the inclusion criteria of participant selection in order to give them an equal chance to participate in the research. I demonstrated justice towards the participants and the mental health care setting by communicating the final findings of the research to all involved parties.

2.6.7 Fidelity

I demonstrated fidelity by keeping promises made towards the mental health care setting as well as towards the participants (Burkhardt & Nathaniel, 2002:59), for example, staying in the allocated time frame of four hours for the data collection sessions, communicating findings of the research and keeping confidentiality.

2.7 SUMMARY

In this chapter, I gave a detailed description of the research design as qualitative, explorative, descriptive and contextual. I discussed Appreciative Inquiry, explaining the first two phases of discovery and dream. I provided details of the research methods in terms of the research setting, the selection of participants, the data collection and analysis, as well as a discussion of the strengths and weaknesses of the research methods. I discussed methods to ensure trustworthiness and the ethical considerations for this research.

CHAPTER 3

DISCUSSION OF THE FINDINGS AND LITERATURE CONTROL

3.1 INTRODUCTION

I will start the following chapter by discussing the demographic profile of psychiatric nurses that participated in this research regarding workplace support. Next, I will discuss the findings that emerged during the data analysis, provide examples from the original data and substantiate the findings with a literature control.

3.2 DEMOGRAPHIC PROFILE OF PARTICIPANTS

All 10 of the participants in my research were female registered psychiatric nurses employed at the specific mental health care setting where I conducted my research. Participants were white, black and coloured. The average age of the participants was 45 years, ranging between 30 and 60 years old.

Both day and night duty staff were represented, with three participants from night duty, six from day duty and one participant who worked both day and night duty. Participants worked 168 hours each month. The majority of the participants were married; two participants were divorced and one was unmarried, with the total of dependants varying between zero and two.

Most of the participants except two had previous psychiatric nursing experience prior to being employed at this mental health care setting. The average time that participants were employed at this mental health care setting was six years, ranging from 18 months to 18 years.

The accessible population in this research consisted of a limited number of possible participants due to the limited number of registered psychiatric nurses in a specific mental health care setting. The sample was limited in terms of race and sex because not all possible participants whom I invited were willing or able to engage in the data collection. I do however, believe that data saturation was achieved (Polit & Beck, 2008:70-71) after the second core group inquiry due to the fact that themes were being repeated and no new

themes emerged. The discussion leaders, my supervisors and the independent co-coder confirmed data saturation.

3.3 DISCUSSION OF FINDINGS AND LITERATURE CONTROL

I conducted the data analysis using information from the different data sources. These data sources included the naïve sketches completed by participants, data from the small core group inquiries and transcriptions from the individual interviews with members of nursing management. Data from the small core group inquiries included written answers on the interview schedule from the one-on-one interviews between participants, transcribed feedback from the discussion phases, positive core maps, results from the nominal group technique, field notes and reflective interviews with the discussion leaders.

During a meeting between the independent co-coder and myself, we reached consensus regarding the use of the Theory for Health Promotion in Nursing as a map or basis for the main emerging themes, since the themes that were identified correlated with the Theory for Health Promotion in Nursing.

The Theory for Health Promotion in Nursing defines the body, mind and spirit as dimensions of the internal environment and the physical, social and spiritual as dimensions of the external environment. The mental health of the psychiatric nurse in this research is influenced by the interaction between both the internal environment and the external environment (University of Johannesburg, 2009:5).

The Theory for Health Promotion in Nursing further defines body as all the biological processes affecting the psychiatric nurse. Mind is defined as all the intellectual, emotional and decision-making processes and spirit is characterised by personal conscience and relationships. Physical is explained as the physical and chemical structures in the external environment, social refers to “human resources in the external environment” and spiritual refers to the values and religious aspects in the external environment of psychiatric nurses participating in the research (University of Johannesburg, 2009:6-7).

It is important to note that although I discussed the various themes that emerged from the different data sources separately, all the themes are interconnected. The Theory for Health Promotion in Nursing further holds that the individual is seen as a holistic being (University of Johannesburg, 2009:4). The examples that I provided from the answers of participants

under one specific theme could also relate to another theme. I attempted to provide examples of the responses of participants as completely as possible in order to clarify the themes and some examples of responses relate to more than one theme, signifying a holistic approach to workplace support. I will refer to the assumptions of Appreciative Inquiry when discussing the findings.

The next section provides a discussion of the central storyline, how a thorn tree became the symbol of the themes and categories relating to workplace support at this mental health care setting.

3.3.1 Central storyline

The very first remark from a participant who gave feedback after the discovery phase of the first small core group inquiry was about the garden at the private mental health care setting where I conducted the research. The participants all felt that the garden was very peaceful and that the entire environment was not only therapeutic for the mental health care users, but also for the employees. They specifically mentioned a thorn tree that was standing just outside the window where we were conducting the small core group inquiry. This thorn tree became a symbol for this organisation of workplace support to the participants of the mental health care setting.

During the first small core group inquiry, while participants were giving feedback, a noise could be heard outside and, on investigation, it was found that members from the garden service were busy cutting branches from a thorn tree. The participants were upset by this and questioned the possible reasons for destroying the tree. Keeping the subject of discussion in mind, namely workplace support and being aware of all the feedback referring to the garden, the participants seemingly felt a sense of loss at seeing the tree being cut.

During the termination phase of the first small core group inquiry participants noticed that the noise outside at the thorn tree had stopped. Further inspection revealed that the tree was only being cut back and not completely cut down as we initially thought. The thorn tree as symbol for this organisation was thus not being annihilated, but only pruned or transformed, thus stimulating modifications and growth.

Based on the responses of the participants to the tree being cut, I decided to use the tree as a metaphor and hence the tree became a symbol of workplace support at this mental health

care setting, and the findings was accordingly represented through the metaphor of the thorn tree, in Figure 3.1. The roots of the tree symbolised the willingness of management to provide workplace support to their employees as seen from the inclusion of various employee support themes in the in-service training programme for the year 2010. The trunk of the tree symbolised the holistic approach to workplace support. The sturdy branches of the tree symbolised the identified themes, solid due to the backing of theory in the form of the Theory for Health Promotion in Nursing.

The identified themes relating to the internal environment were supporting the body as the physical dimension of the psychiatric nurse, supporting the mind as the cognitive and emotional dimension of the psychiatric nurse and supporting the spirit as the relationship and conscience dimension of the psychiatric nurse. The identified themes that were related to the external environment were support in terms of the physical environment of the psychiatric nurse, support in terms of the social environment of the psychiatric nurse and support in terms of the spiritual environment of the psychiatric nurse.

The discovery phase leads to the appreciation of valuable and effective workplace support systems that were already implemented at this mental health care setting. The participants had sufficient experiences to share during their one-on-one interviews regarding effective workplace support, since I noted in my field notes that the allocated time of 15 minutes did not seem to be adequate for participants to complete their questions. I did, however, provide extra time to allow participants to complete their one-on-one interviews.

I represented the discovery phase categories as the beautiful green leaves of the tree due to the fact that existing workplace support is already being implemented, which promoted the mental health of psychiatric nurses. This correlates with the intent of the discovery phase of Appreciative Inquiry which is to seek out that which gives energy to the organisation or to “appreciate what is” (Whitney & Trosten-Bloom, 2003:6).

I chose to portray the wishes of the participants that emerged during the dream phases as pink buds, due to the hidden possibilities embedded in the dreams of these psychiatric nurses. This correlates with the intent of the dream phase of Appreciative Inquiry which is to develop ideas regarding the future or to “imagine what might be” (Whitney & Trosten-Bloom, 2003:6). In chapter 4, I will provide recommendations based on the wishes of the participants related to the research findings. The pruning of the thorn tree symbolised potential transformation and future growth for both this organisation and psychiatric nurses

employed here. People and organisations will grow and flourish as long as they embrace a positive future image (Cooperrider, et al. 2008:13).

Throughout the analysis of the data it seemed at first as if the identified categories from the discovery phase and the wishes from the dream phase of the two core group inquiries were contradictory. The participants would recollect a peak experience regarding workplace support during the writing of the naïve sketches or during the discovery phase and wish for additional or improved versions of precisely the same phenomenon during the dream phase. Cooperrider et al. (2008:44) explain this by defining the dream phase as an expansion of the discovery phase and a concentration on the positive core, formulating an improved future.

The following figure (Figure 3.1) is a tree representing the central storyline, the themes and categories that emerged during the data analysis of my research on workplace support at a private mental health care setting. I will start the discussion of the findings with a section named a holistic approach to workplace support, which was the central theme. Following this central theme of a holistic approach to workplace support, I will discuss the themes or branches of the tree separately. The categories are represented as green leaves or pink buds, which I will discuss under each theme. The green leaves represent the discovery phase categories while the pink buds represent the dream phase categories. The green leaves represent the discussion of the discovery phase categories and will each time be followed by the discussion of the dream phase categories or pink buds under each theme or branch in order to indicate the close link between what participants experienced and what they wished for in relation to workplace support. The texts that are indicated in italics are either verbatim responses from participants or written answers from participants that were used without adjustments.

3.3.2 Holistic approach to workplace support

According to the Theory for Health Promotion in Nursing, the nurse (psychiatric nurse in this research) is seen as in interaction with the internal and external environments in a holistic fashion (University of Johannesburg, 2009:4). The holistic approach to workplace support in this research will focus on workplace support provided by management, including nursing management, directors and medical superintendent of this mental health care setting.

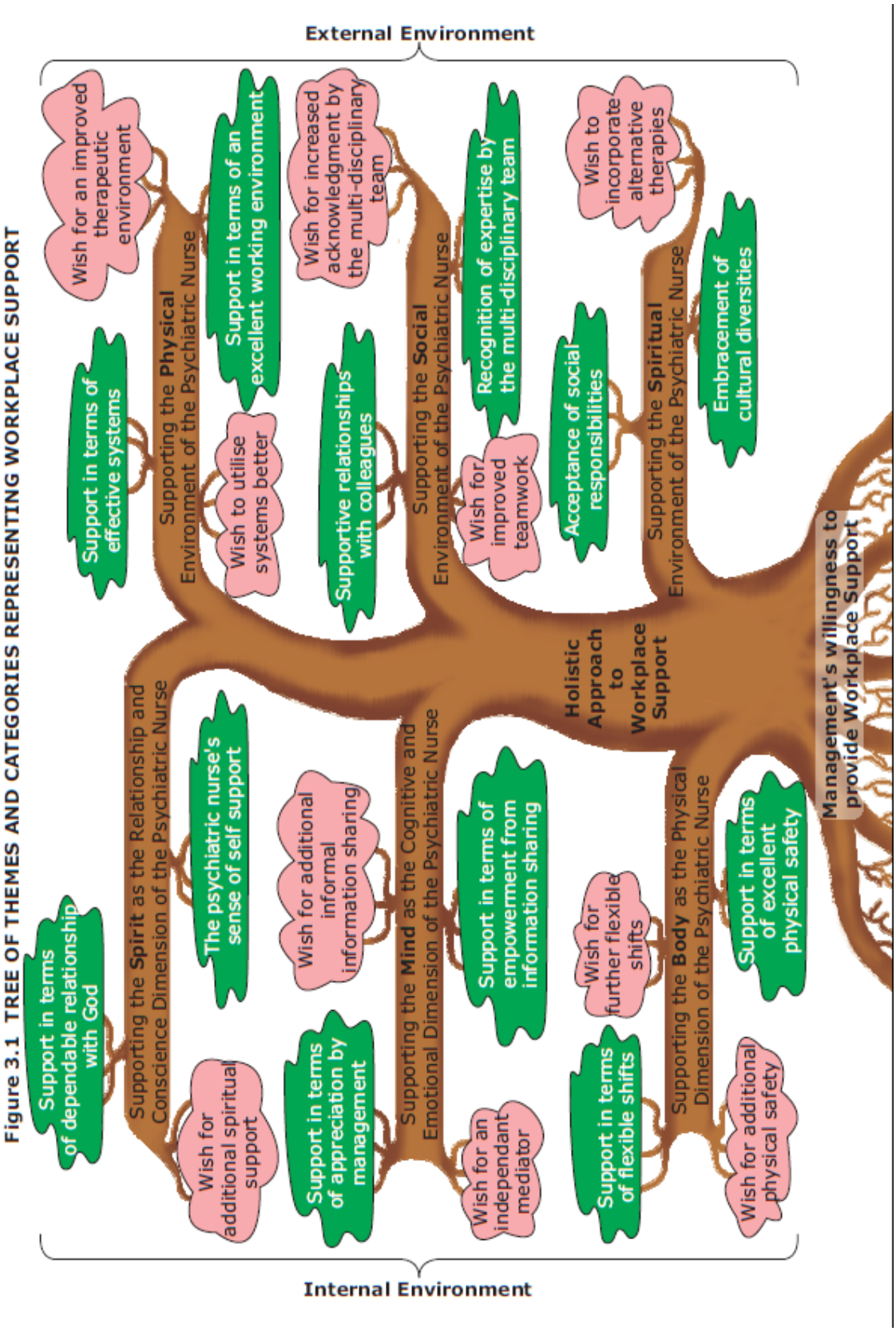

Figure 3.1 TREE OF THEMES AND CATEGORIES REPRESENTING WORKPLACE SUPPORT

Kneisl and Trigoboff (2009:827) define holistic by explaining that there is a dual meaning to holism: one is to recognise "the interrelationship of the bio-psycho-social-spiritual

dimensions" of an individual and to "recognise that the whole is greater than the sum of its parts"; the other involves the individual "as a unitary whole in mutual process with the environment". This definition of the concept holistic correlates with the holistic view of an individual in the Theory for Health Promotion in Nursing by reflecting on the interaction with the environment (internal and external).

The provision of workplace support addresses the aspects of a holistic individual, including the internal environment of body, mind and spirit and the external environment of physical, social and spiritual dimensions of the psychiatric nurse. All of the identified themes and categories can thus be summarised as being part of a holistic approach to workplace support.

This holistic approach to workplace support was evident in the field notes that I made during one of the small core group inquiries. I was surprised by the wide variety of themes that emerged during the discussion phase feedback of one of the small core group inquiries, indicating that psychiatric nurses experienced many different things as being supportive. I wrote in the field notes:

"Groot verskeidenheid temas geïdentifiseer." (Identified a large variety of themes.)

There are interventions that an organisation can employ to increase the retention of employees or to provide workplace support, which reflect the holistic nature of workplace support. Several studies have been conducted on workplace support and the diversity of discussed themes indicates that a holistic approach to workplace support is needed. Manion (2005:95) listed autonomy, relationships, recognition, competence and environment as interventions, while Coetzee (2010:249) listed compensation, supervision, training, independence and the work environment. Nielsen, Randall, Yarker and Brenner (2008:27) state that experiences of the opportunities for development and a meaningful work environment can facilitate the well-being of employers. Edwards and Burnard (2003:195-196) additionally show how peer support and fitness levels can contribute to coping strategies in their research on "stress management interventions for mental health nurses", correlating with findings in this research.

Jackson et al. (2007:2) state that resilience transpires as a result of a collection of psychological and physical factors, resulting in homeostatic mechanisms to manage workplace stresses. Being aware of the holistic nature of individuals also resonance with the

wholeness principle of Appreciative Inquiry.

I will discuss the themes and categories that stemmed from the central theme of a holistic approach to workplace support under two main headings, namely the internal environment of the psychiatric nurse and the external environment of the psychiatric nurse.

3.3.3 Internal environment of the psychiatric nurse

There are three themes describing the internal environment of the psychiatric nurse, namely supporting the body as the physical dimension of the psychiatric nurse, supporting the mind as the cognitive and emotional dimension of the psychiatric nurse and supporting the spirit as the relationship and conscience dimension of the psychiatric nurse. I will discuss each theme of the internal environment followed by the various categories, divided into the discovery phase categories and the dream phase categories. The discovery phase categories are represented by green leaves and the dream phase categories are represented by pink buds in the figure of the tree of themes and categories representing workplace support (Figure 3.1).

3.3.3.1 Supporting the body as the physical dimension of the psychiatric nurse

Supporting the body as the physical dimension of the psychiatric nurse refers to support in terms of the anatomical structures and biological processes of the individual (University of Johannesburg, 2009:6) or the psychiatric nurse in this research. The discovery phase categories that were included in this theme were support in terms of flexible shifts and support in terms of excellent physical safety. The dream phase categories that were included in this theme were a wish for further flexible shifts and a wish for additional physical safety.

Schultz, Bagraim, Potgieter, Viedge and Werner (2005:212) indicated the importance of physical wellbeing by listing personal illness and injury fourth on the shortened version of the significant life events scale that can predict future illness.

a) Discovery phase categories relating to the body of the psychiatric nurse

Two categories were identified from the results of the discovery phases of this research relating to the theme of supporting the body as the physical dimension of the psychiatric

nurse, namely support in terms of flexible shifts and support in terms of excellent physical safety.

a.i) Support in terms of flexible shifts

During the discovery phases of the small core group inquiries, participants verbalised their appreciation concerning the flexibility that nursing management of this mental health care setting maintained towards their shifts or working hours. Participants experienced that members of nursing management who were coordinating their shifts were accommodating towards their needs in terms of off-duty times. The reasons for asking for off-duty time on short notice can be found in the internal environments of psychiatric nurses, like feeling physically or emotionally tired due to the nature of psychiatric nursing, or in their external environments due to family responsibilities.

This relates to the theme of supporting the body of the psychiatric nurse in terms of providing physical rest when needed. Support in terms of flexible shifts also links with other identified themes like supporting the mind as the cognitive and emotional dimension of the psychiatric nurse by providing mental and emotional rest when needed.

Participants reflected on the support in terms of flexible shifts during the small core group inquiries as follows:

"They are very accommodating towards your working hours. If you have a problem also, they are very accommodative."

"Last week for instance, I worked, and by Friday I was absolutely exhausted and Saturday morning I phoned and said please could I have two days leave. I am not going to cope my inner being realised that I was absolutely exhausted, because of the kind of patients I had. They were absolutely accommodating me and said I could take two nights off, and I am feeling wonderful because I (had) *time to debrief."*

The following dialogue occurred during the feedback and group discussion session after the discovery phase:

Discussion leader: *"So, at some stages they* (members from nursing management) *do recognise that there is a challenge,* (regarding family responsibility) *and they react to it. So*

that spirit of accommodation?"

Participant 3: *"They usually accommodate us."*

Participant 4: *"It is something that they do. They are not this rigid."*

Participant 1: *They told me they can accommodate me, it was not like you can't go* (on leave) *now."*

Discussion leader: *"What I pick up from you is a sense of flexibility?"*

Participant 1: *"Absolutely."*

Findings in this research is confirmed by Booyens (2008:363), arguing that absenteeism among nurses can be reduced by the implementation of accommodating staffing schedules. Manion (2009:134) continues to describe how "scheduling practices" by the organisation can aid in meeting the needs of the employees by implementing flexible hours and by responding timely to the requests of employees in terms of off-duty time. These short-notice requests for off-duty times by psychiatric nurses can be due to the nature of mental health nursing and the challenges posed by the mental health care users. Support by nursing management in terms of flexible shifts thus indicates a commitment to providing workplace support to facilitate the promotion of the mental health of psychiatric nurses.

A self-scheduling process by psychiatric nurses can promote staff autonomy, increase accountability of staff, enhance negotiating and problem-solving skills and promote team communication (Yoder-Wise, 2011:286). A self-scheduling process entails that psychiatric nurses, enrolled nurses and care workers who work together in one ward take responsibility to coordinate their own working times.

a.ii) Support in terms of excellent physical safety

Support in terms of excellent physical safety refers to the views of participants on the importance of feeling safe at work. These views included the relationship between psychiatric nurses and the security staff, as well as colleagues working in the different wards. Currently security staff positioned at one central gate control the vehicles and individuals, including mental health care users, visitors and staff members who enter and

leave the premises. Support in terms of excellent physical safety also correlates with the category of supporting the physical environment of the psychiatric nurse by providing a safe working environment.

Psychiatric nurses work in challenging contexts that might have an impact on their physical safety. Mental health care users can be aggressive and unpredictable and might assault psychiatric nurses. The increase in the acuity levels of clients can contribute to the increase in violence in mental health care facilities (Kneisl & Trigoboff, 2009:913).

Support in terms of excellent physical safety also refers to the skills of psychiatric nurses regarding the management of an aggressive mental health care user. Skills can be improved by providing in-service training, which will connect this category with the category of supporting the mind as the cognitive and emotional dimension of the psychiatric nurse. The participants also verbalised that they felt secure in the knowledge that they can call security staff members or staff members from other wards if needed in a crisis situation.

A participant made the following comment relating to excellent physical safety during the discovery phase of a small core group inquiry:

"And what we can add to that list is security. They (security personnel) *know the staff really well if you enter, they uhm, know how to handle the people, who must come in and who not. It makes you feel very safe, and they will also come and help with the difficult patient if it is really necessary."*

During the feedback phase of one of the small core group inquiries, after the discussion leader asked for clarification, a participant also shared the experience of colleagues who were available in a crisis when the psychiatric nurses physical safety were endangered.

Discussion leader: *"OK, so I just want to be clear on that. So sometimes people will just come and support you. Maybe by just being present?"*

Participant: *"To keep you safe, especially when there is a patient that might be challenging your safety."* (The physical safety of the psychiatric nurse.)

Uys (2004:254) wrote, "violence forms part of mental health nursing". Due to the instability of the mental illnesses of the mental health care users who are admitted to a mental health

care setting, the occurrence of urgent situations is common, despite the use of danger avoidance strategies by psychiatric nurses (Deacon, Warne & McAndrew, 2006:754). Rao, Luty and Trathen (2007:756) show that mental health care users with a dual diagnosis of substance use disorder and severe mental illness are significantly more prone to hostile behaviour and violence. Irwin (2006:310) confirms this by suggesting that, given the scope of situations and characteristics, it is complex to identify the cause of aggression in individuals, but suggests that individuals with severe mental illness, combined with substance abuse, is significantly more likely to perform aggressive acts.

Participants expressed their appreciation for the support from the security personnel and other staff members who were available in a crisis.

Lesinskiene, Jegorova and Ranceva (2007:762) suggest that an increase in the number of male staff and training can reduce the incidence of aggression in a mental health care setting. Security in an acute mental health care setting can involve the protection of psychotic mental health care users from over stimulation, the close observation of suicidal mental health care users and the reassuring of agitated and anxious mental health care users (Schoppmann & Lüthi, 2009:611).

Lepping, Steinert, Needham, Abderhalden, Flammer and Schmid (2009:633) explain how the perceived potential to intervene in a crisis situation, or managers confidence in the resources, protocols, training and skills of their staff members, can reduce the actual number of staff members needed to deal with violence. Lepping, et al. (2009:634) suggest regular training, clear protocol regarding the management of violence and risk assessment in order to increase staff members' confidence in violent situations. Irwin (2006:315-316) identifies factors that can aid in the management of aggressive behaviour in a mental health care setting, namely to perform risk assessment of mental health care users, to review risk assessments regularly, to ensure a therapeutic milieu where the psychiatric nurses uses communication techniques and effective interaction with mental health care users and to ensure that psychiatric nurses demonstrate skills and knowledge in the management of aggression.

A risk assessment can reveal several interacting trigger factors for aggression in a mental health care user and can aid the psychiatric nurse in the formulation of a nursing care plan in order to formulate several interventions in order to reduce aggressive behaviour (Hage, Van Meijel, Fluttert & Berden, 2009:664).

Due to the direction of modern mental health services that aims to provide a less restrictive and therapeutic environment for the mental health care users, it is necessary to carefully employ protocol on banned items, restrictions and searching of mental health care users, the use of security guards, alarms and close circuit television (Cowman & Bowers, 2008:1352). This can be linked to the categories of a wish for additional information sharing and a wish to utilise systems better.

Despite this appreciation for support in terms of flexible shifts and support in terms of excellent physical safety, participants wished for further flexible shifts and additional safety during the dream phase.

b) Dream phase categories relating to the body of the psychiatric nurse

Two categories were identified as wishes resulting from the dream phase of this research relating to the theme of supporting the body as the physical dimension of the psychiatric nurse, namely a wish for further flexible shifts and a wish for additional physical safety.

b.i) Wish for further flexible shifts

During the discovery phase, participants expressed their appreciation for the concerning attitude of nursing management regarding the flexibility of shifts, usually on short notice or when they were feeling physically or emotionally tired. They viewed this as a way of experiencing workplace support. Participants however, wished for even more flexible hours during the dream phase of this research.

Psychiatric nurses working night duty at this mental health care setting worked seven nights consecutively, followed by seven nights off duty. Psychiatric nurses who were working day duty worked on a fixed schedule of two to three days on and two days off, working every second Friday and every second weekend. A participant working night duty verbalised a need to work fewer nights consecutively, while a participant from day duty verbalised a wish to incorporate more flexibility in the fixed schedule. A psychiatric nurse made the following comment during the discussion phase following a dream phase:

"There is just something else, in a dream, to work night shift, if one could, I would have liked, and I really would like to talk to matron about it, if I could work for three nights one week and four nights the other week."

Another psychiatric nurse verbalised the same wish during the discussion phase, but for a different reason.

"Yes, that is the thing about working for 12 hour for seven nights, because with teenagers and certain personalities, you get naturally irritated after a while. I really think 12 hours for seven nights is too long. Like office hours, so you have three shifts, instead of two shifts for 24 hours per day."

Accommodating working hours could be influenced by older employees who might find long hours physically demanding, or by younger employees who would prefer to cluster their hours together in order to have longer breaks for their personal life (Manion, 2009:405).

The reasons for participants verbalising the same wish for further flexible shifts put the focus on an assumption of Appreciative Inquiry, namely that "it is important to value differences" (Reed, 2007:28). These differences in experience between participants might also explain why the category of flexible shifts emerged during the discovery phase as a way for providing workplace support and during the dream phase as a wish.

b.ii) Wish for additional physical safety

One participant who was threatened and physically assaulted by a mental health care user asked the following question during the discussion phase of one of the core group inquiries, indicating her concern for her physical safety.

"I do not know if this is a dream, but what is the protocol about a patient hitting you, injuring you in such a state?"

In answering this question, one of the other participants reflected the uncertainty and illuminated the wish for training of psychiatric nurses, in terms of information and skills, concerning the management of aggressive mental health care users in order to maintain their physical safety.

"It depends, if the patient is psychotic, is he focussing, was he in reality, was he provoked, was it medication, was he hallucinating."

This answer might also indicate a need for the introduction of protocol regarding aggressive mental health care users, linking the category of a wish for additional physical safety to the category of a wish to use systems more effectively. This comment regarding training also links with the theme of supporting the mind as the cognitive and emotional dimension of the psychiatric nurse.

Uys (2004:255) define violence as any physical behaviour that can result in injury to others or self or which causes damage to property. The physical risk posed to psychiatric nurses due to the fact that some mental health care users can be aggressive and the subsequent need to feel physically safe became evident when the participants verbalised the wish for additional safety. As targets of aggression, psychiatric nurses are highly at risk and up to half psychiatric nurses were attacked in some way during their career (Chen, et al. 2005:146). Mental disorders that can be associated with aggressiveness include borderline and antisocial personality disorders, conduct disorder, delusional disorder, intermitted explosive disorder, dementia of the Alzheimer's type, substance-related disorders and schizophrenia (Kneisl & Trigoboff, 2009:916).

The verbalised need for information-sharing regarding the management of an aggressive mental health care user by participants highlighted the need for information on aggression. Information sharing in terms of knowledge regarding aggression, as well as skills to handle the aggression of a patient, is essential for nurses to manage these aggressive incidents (Chen, et al. 2005:146). Yoder-Wise (2011:59) continues to argue for “special attention” regarding violence in the workplace, which includes sufficient in-service training such as effective crisis intervention and the management of highly agitated mental health care users. Kneisl and Trigoboff (2009:894) define crisis intervention as a conceptual framework aimed at intervention for short-term assistance, focused on problem solving, in order to restore the equilibrium of an individual.

Four categories regarding the theme of supporting the body as the physical dimension of the psychiatric nurse were discussed, including support in terms of flexible shifts, support in terms of excellent safety, a wish for additional safety and a wish for even more flexible shifts. The body forms part of the internal environment of an individual, along with dimensions of mind and spirit (University of Johannesburg, 2009:5). The following theme that forms part of the internal environment, namely supporting the mind as the cognitive and emotional dimension of the psychiatric nurse, will be discussed next.

3.3.3.2 Supporting the mind as the cognitive and emotional dimension of the psychiatric nurse

The theme of supporting the mind as the cognitive and emotional dimension of the psychiatric nurse forms the second branch of the tree (Figure 3.1). The mind as the cognitive and emotional dimension of the psychiatric nurse includes decision-making processes, with the cognitive dimension referring to all the processes of thinking, analysis, association, understanding and judgement. The emotional dimension relates to the affection, feelings and desires of the individual, or the psychiatric nurse in this research (University of Johannesburg, 2009:6).

The discovery phase categories included in this theme were support in terms of empowerment by means of information sharing, referring to the cognitive dimension and support in terms of the appreciation of management, referring to the emotional dimension of the psychiatric nurse. The dream phase categories included in this theme were a wish for additional information sharing, referring to the cognitive dimension, and a wish for an independent mediator, referring to the emotional dimension of the psychiatric nurse.

a) Discovery phase categories relating to supporting the mind of the psychiatric nurse

The two categories that emerged during the discovery phase of the data collection in relation to the theme of supporting the mind as the cognitive and emotional dimension of the psychiatric nurse were support in terms of empowerment by means information sharing and support in terms of the appreciation of management.

a.i) Support in terms of empowerment from information sharing

Information sharing at this mental health care setting transpires through the use of formal and informal processes. The formal information sharing occurs as a formal, compulsory monthly meeting that takes place in off-duty time and which is aimed at in-service training. It lasts approximately four hours. Private tutors or various invited experts are afforded an opportunity to share information with the nurses (psychiatric nurses and auxiliary nurses) relating to the in-service training programme for the year. During the period of this research, the formal information-sharing programme included personal support topics on posture, diet, lifestyle choices and stress management.

Informal information sharing occurs during on-duty time and attendance depends on the acuity levels of the mental health care users at the time of training, as well as the availability of psychiatric nurses from each ward. Informal information sharing transpires by the following means: through journal clubs on each shift that meet once every second week for an hour; weekly meetings with some of the psychiatrists; the orientation of new staff or casual workers in the wards by members from senior or middle management; and informal training in the ward setting on any relevant topic when the need arises. The formal and informal information sharing links to the cognitive dimension of the psychiatric nurse, as discussed in paragraph 3.3.3.2.

Participants from both small core group inquiries reflected on the importance of the formal training, as shown by the following examples:

"We have also mentioned in-service training. You do not always like to be here on an off day, it is awkward, but it, uhm, empowers you to get knowledge."

One participant described the formal training as follows:

"Yes, this month we've got another one (formal in-service training) *on a Tuesday. One of the psychologists comes to talk to us, the dietician, and an occupational therapist. There are doctors that are doing research in the hospital. There are a few doctors doing it here, and they are doing it in their own practices as well. We have also started a journal club. There are a few of us nurses that are writing stuff, not major stuff that are published, we get info, new medication or alternative uses. There is a journal club that is being formulated."*

This reference to the journal club highlighted the importance of the informal information sharing by participants. The following narrative by a participant from one of the small core group inquiries summarised the informal information sharing:

"He (psychiatrist) *also tells us more about the patient that is difficult. We do not always have access to all the information about the patient. We also get 'inligtingsbrosjures'* (information leaflets) *about the physical diseases. Sometimes we admit somebody with something that is very rare. It is interesting and every ward gets one. We enjoy that."*

The following comment by a participant explained the informal information sharing further:

"We have also said, uhm, uhm, one Thursday every month we have an open meeting with doctor (name). We talk about psychiatry, uhm, some of them will encourage you, and will listen to you. It is also as if you can debrief. If you talk to doctor (name) and you know that there is someone who is listening, it is like a group session they take a sister or a staff nurse out off the ward, and then we have a meeting for about an hour. He asks us what do you want to talk about, and if someone's got a problem, we talk about it ... you can talk about one of the patients that you've got, or the condition that the patient have. If you do not understand something about the treatment, you can ask him."

Kiley (2010:395) define in-service training as coaching that is conducted by a supervisor or a colleague that is more experienced in the work environment, and differentiate between unstructured training that is more informal and structured or planned formal training.

In the context of this research, formal training refers to a planned programme consisting of a monthly, four-hour long meeting. Attendance of this monthly training is compulsory for psychiatric nurses and auxiliary nurses and it includes themes like self-care, time management, nutrition and exercise. Apart from focussing purely on occupational topics, training ought to include development and personal issues like time and stress management as a means of improving the overall health of the employees (Coetzee, 2010:266).

Participants verbalised the benefit and the support that they experienced from both the formal and informal training during the discovery phase of this research. An educational programme can increase staff morale, increase involvement and working relationships as well as communication (Chambers, Connor & Davren, 2006:368). Chambers et al. (2006:370) added improved client care, improved information flow, increased research interest and staff development as advantages of an educational programme in mental health. Spence Laschinger, Leiter, Day and Gilin (2009:303) define access to information as knowledge of organisational goals and decisions, as well as technical expertise and knowledge, leading to a sense of purpose for employees and enhancing their abilities.

Satisfaction with the amount and quality of the in-service training can have a positive influence on the retention of psychiatric nurses (Edwards & Burnard, 2003:196). A wish for additional informal information sharing, however, emerged during the dream phase of this research, possibly due to the time requirements of the formal information sharing and the more relaxed nature of the informal information sharing. I will discuss the wish for additional informal information sharing under b.i.

Kiley (2010:371) argue that individuals are motivated towards personal growth as a means to realise self-actualisation through development, learning and training. This statement links to the poetic principle of Appreciative Inquiry that suggests that learning "describes, even creates, the world as we know it" (Whitney & Trosten-Bloom, 2003:54).

a.ii) Support in terms of appreciation by management

Participants in both core group inquiries and participants from the individual interviews verbalised a sense of feeling heard; they felt supported and appreciated because of the actions of members of nursing management and senior management. The acts of appreciation made participants feel as if they had value to add to the organisation that employed them. Support included availability to assist with challenging mental health care users as well as coaching and mentoring regarding leadership skills. Psychiatric nurses from the small core group inquiries experienced support from nursing management, while members from nursing management with whom I conducted individual interviews, experienced support from their colleagues (senior management and hospital management).

This appreciative attitude from nursing management towards psychiatric nurses is apparent in the way that one nursing manager verbalised the relationship with the senior psychiatric nurses during an individual interview.

"The senior head nurses is my ears, feet, hands, everything. I have the utmost respect and confidence in them, I know and trust that things are being done, and done correctly. It meant a lot when we took them out of the wards. They are always available for the whole hospital. When I am off duty, I know everything will be all right, I trust their knowledge and skills."

The following comment from a participant illustrates the value that is assigned to the appreciation coming from nursing management. The appreciation was about feeling valued and cherished.

"They talk about, uhm, they ask you how you are, and also interested in your personal life … it is a caring attitude."

Participants from both the small core group inquiries and members from nursing management who participated in the individual interviews verbalised a strong sense of

belonging and of being heard and appreciated. This feeling of being supported by management was made evident by the following comments:

"If you have a problem also, they are very accommodative. You feel heard, they hear what you are saying, it will also make you feel like you belong here in a sense, they (members from management) *know you."*

"Yes, often it felt just like the right time. She (a member from nursing management) *knew I was feeling not well. Yes well, if you have a difficult patient it would make all the difference. It it is not as if I find it intimidating when she comes in and help with the situation, I am not therapeutic now I'm getting angry at you or helping out, she would come in and take over the situation with a fresh approach without intimidating or insulting. If she can come in and take over, we have the teambuilding approach to the patients."*

Another participant confirmed this support from members of nursing management during another discussion phase by making the following comment:

"Yes and she (referring to a member of nursing management) *really listen when you talk to her. You feel free to talk to her, and it is always confidential. They* (members from nursing management) *will always give advice, but they will not go behind your back and gossip. I really trust her … reinforcement of good behaviour, not always the bad stuff* (referring to negative feedback)*".*

This appreciation, support, sincere listening, respect and professional conduct by nursing management and members of hospital management towards psychiatric nurses are apparent even to members of middle nursing management, as can be seen by this remark from one of the individual interviews:

"Also, when I was promoted to a senior post they mentored me up to a stage that I could go on on my own. During weekends and every afternoon when I'm alone in charge, of the hospital, they (members from nursing management) *make me feel really in charge and respect the decisions I make in their absence. If there is any correcting measures that needs to be done regarding my interventions that is done respectively and consultatively."*

Profit sharing is another aspect that the participants experienced as being supportive in terms of making them feel appreciated.

"Profit-sharing, we get it once or twice a year, it tells us something, that we are valued."

A participant made the following comment during a discussion phase following the dream phase of a small core group inquiry:

"I even want to connect the profit sharing situation with the honesty, because it is a combination. They show that they do appreciate us by giving us something and they are honest enough to acknowledge it. We are important enough to get it."

Bussin (2010:313) defines profit sharing as a form of short-term incentive that can be applied for up to a year. The purpose of profit sharing is, among others, to reward excellent performance and is an acknowledgement of "a job well done" (Bussin, 2010:314). The participants experienced this acknowledgement in the form of profit sharing as being supportive in the sense that they felt acknowledged by management. Leiter and Maslach (2009:337) also commented that organisational justice, respect and fairness could be seen in the distribution of rewards.

Respect for psychiatric nurses by nursing management and hospital management, as a form of showing appreciation, was evident in the narratives of participants. This respect was shown in the form of being physically available, demonstrating effective listening, showing interest and profit sharing. Respect means the valuing of the skills, abilities or talents of another and is based on the contributions, or potential contributions, of individuals (Manion, 2009:184).

Skilled managers, who can balance client loads, ensure a therapeutic and safe environment, provide supervision, organise staff, negotiate relations between the multi disciplinary team and liaison with senior management, are important to the psychiatric nurses' well-being (Hanrahan, et al. 2010:203). Feather (2009:381) stresses emotional intelligence in nurse leaders, arguing that nurse turnover may be decreased by emotional skills development in nurse leaders.

The findings in this research is confirmed by the findings of Hanrahan et al. (2010:204), that show a significant correlation between feelings of being valued by members of nursing management in psychiatric nurses and the absence of emotional exhaustion. Olofsson (2005:264) equally shows how psychiatric nurses verbalised the importance of confirmation of their work, stressing the supervisors' trustworthiness during feedback.

This respect can be communicated in various ways like performing facilitating actions, demonstrating a caring attitude, supporting and trying to meet employees needs, active listening, being respectful, expressing recognition and appreciation, valuing commitment, providing a vision, motivating employees, developing staff by means of educational programmes, demonstrating a positive feeling in the workplace and effective communication of goals and objectives (Coetzee, 2010:262; Manion, 2009:133; Yoder-Wise, 2011:55-56).

Respect and appreciation can also lead to loyalty towards the leadership team and can facilitate the breaking down of barriers and the mobilisation of employees towards an enhanced future (Manion, 2009:209).

b) Dream phase categories relating to supporting the mind of the psychiatric nurse

The two categories that emerged during the dream phase of the data collection relating to the theme of supporting the mind as the cognitive and emotional dimension of the psychiatric nurse were a wish for additional information sharing and a wish for an independent mediator.

b.i) Wish for additional informal information sharing

Informal information sharing at this mental health care setting transpires through journal clubs on each shift that meet once every second week for an hour, weekly meetings with some of the psychiatrists, the orientation of new staff or casual workers in the wards by members from senior or middle management and informal training in the ward setting on any relevant topic when the need arises.

It is clear from the examples of the discovery phase reflected above that participants valued the informal training they received and that they viewed it as an effective way of providing of workplace support. There were, however, participants who verbalised a need for additional informal information sharing. Participants who wished for additional informal information sharing during the dream phase felt that the formal training was time consuming and too structured. Participants also expressed the need to have more control over the information, like suggesting topics for information sharing, as opposed to a topic being allocated to the formal information sharing programme for the year.

It seems as if some participants perceived an unequal distribution of information-sharing opportunities between the day and the night staff. An additional wish for a more structured approach to informal information sharing emerged during the dream phases of the small core group inquiries. The following verbatim quotes reflect the perception of night staff that they felt there was an unequal distribution of informal information sharing between the day and night staff:

"Something that I would really appreciate is this kind of knowledge (informal information sharing) *would come through to the night staff. We really feel there is a lack of communication, and lack of information and input. I just think it is extremely important that we should feel like a whole with the day duty."*

Participants from both the core groups dreamed about a more structured orientation for new psychiatric nurses who were employed or who worked on an irregular basis. Participants reflected the wish for a more structured orientation for non-permanent employees as follows:

"… yes, but as I said we have a structure in place. The senior sister has to orientate and go through the list, and make sure that they understand what we are doing here, what the routine is. It is a low-down if you are stuck with the agency sister, who does not know anything, but in an ideal world it is supposed to work that way, but it does not always work that way."

An analysis of the training needs of employees by members of nursing management could also reveal a difference between what is provided at the moment and what the wishes of psychiatric nurses are in terms of the need for more informal information sharing as verbalised by day and night staff members. The following statement from one of the participants during one of the dream phases illustrates the training needs of participants:

"If we could have, or like a seminar, you know more often, we say for instance somebody comes in and talk to us about one or other criteria, uhm, we could have short sessions of information, we could have medicine, information from the doctor, psychologist we could have, I know it is necessary, but five hours is too much. What we can also have is in-service training in the ward."

Another suggestion regarding the training needs of the participants that emerged during a dream phase is illustrated below.

"What we can have is example (medicine name) *and you could do this and this and this with it. You can gather the people quickly up* (informal training in the wards) *and it is not this big thing we must do like formal, everybody must be here at this time, etcetera. We have the structures in place, but if we can only prop it up a bit."*

Another psychiatric nurse who made the following suggestion regarding the informal training needs of the students who are allocated to this mental health care setting from time to time added to this comment:

"Like the students, I really think that they can enhance it a bit, like the more senior people, when there (are) *students in the ward, you can really give like a lecture in the ward. Make it more a learning experience for the students."*

During the feedback phase of one of the small core group inquiries, one of the participants expressed the value of taking ownership for her learning as follows:

"I like, because I am very inquisitive, I, many times I have got it already and I will ask some information about this or this, and she will go onto the internet and look for this and this, so for me it is always my own responsibility to always be a student. That is in a way my dream that everybody would like to be a student. But I think, if I can add on the positive side, if you have a ward, or an environment that is learning orientated, ok, let me go and read or go and find out, and come and tell everybody at work, so it does not need to be a formal thing, you can go and start it on your own. If you have read something interesting, and you want to share it with somebody, it creates that environment."

Findings in this research correlates with findings from Sun, Long, Boore and Tsao (2006:90), who argue that psychiatric nurses may feel powerless due to insufficient or ineffective training. In-service training courses are usually directed towards the updating of employees regarding new treatments and diagnostic techniques, new equipment and new organisational policies (Booyens, 2008:384). Kiley (2010:389) suggest performing an analysis of the training needs of employees, which is an indication of the disparity between what is currently taking place and what ought to be facilitated in terms of training.

Verbalising the wish for additional informal information sharing can lead to the accomplishment of joint responsibilities for the implementation of evidence-based practice (Marquis & Huston, 2009:379). Evidence-based practice is defined by Polit and Beck

(2008:753) as clinical decision making in practice based "on the best available evidence", emphasising evidence from research. The implementation of evidence-based practice in this context might entail the use of the best available evidence from research when formulating working protocols, when providing information during formal and informal training and the motivation of psychiatric nurses to join and actively participate in the journal clubs.

Marquis and Huston (2009:379) suggest building consensus with the multi-disciplinary team and making research findings available, while providing educational support by helping staff with the interpretation of research reports. Schoppmann and Lüthi (2009:614) emphasise the importance for nurses to learn from each other, calling on each other's expertise and discussing theoretical concepts.

The results from a study performed by Lautizi, Laschinger and Ravazzolo (2009:450) show that providing opportunities for professional development and learning are important for mental health nurses' job satisfaction. Lautizi et al. (2009:451) however stress that management from a mental health care setting ought to create structures, systems and protocol to enable psychiatric nurses to practice according to professional standards, optimising their knowledge and skills.

Marquis and Huston (2009:389) highlight the need to celebrate the educational needs of a cultural diverse staff. The wish for additional informal information sharing thus correlates with the category of embracement of cultural diversities. The wish for additional informal information sharing also correlates with the category of a wish for increased acknowledgement by the multi-disciplinary team, the category of support in terms of appreciation by management and the category of a wish to incorporate alternative therapies.

b.ii) Wish for an independent mediator

An independent mediator in this research refers to an independent psychiatric nurse who could be made available for psychiatric nurses to consult regarding workplace-related stresses or even personal issues if needed. The wish for an independent mediator that participants could talk to was illustrated by a comment during one of the dream phases:

“Dit is net 'n droom, iets wat ek graag sal wil doen. (It is only a dream, something that I would like to do.) *It is just to have a psychiatric nurse in the clinic that does counselling to staff, that is available daily.”*

A participant substantiated this comment during feedback on the dream phase during a small core group inquiry:

"Not a psychologist, but a psychiatric nurse. That knows what is happening at work. That gives debriefing for the personnel."

Okun and Kantrowitz (2008:323) define critical incident-stress debriefing as debriefing that limits or prevents the development of posttraumatic stress in individuals who were "exposed to a critical incident", where a critical incident is an event that caused an intense stress reaction. Sharrock, Grigg, Happell, Keeble-Devlin and Jennings (2006:40) describe how an organisation could use the expertise of a "psychiatric consultation-liaison nurse" to manage matters relating to the mental health of employees by focussing on debriefing after stressful incidents or addressing other aspects of employee mental health. Manion (2009:336) refers to an "employee assistance programme" to provide counselling, coaching or debriefing for employees as a means of providing support.

This need to debrief and the verbalisation of a wish for an independent mediator by participants highlighted the importance of counselling for psychiatric nurses working at this mental health care setting in order to facilitate the promotion of their mental health. An advanced psychiatric nurse practitioner is a registered nurse who is "educationally prepared as a clinical nurse specialist or a nurse practitioner at the master's or doctorate level in the speciality of psychiatric-mental health nursing" and who may conduct psychotherapy and consultation (Kneisl & Trigoboff, 2009:21-22). Seed et al. (2010:168) recommend using a clinical nurse specialist to coordinate the care of mental health care users, thus improving satisfaction and retention rates of psychiatric nurses.

The category of a wish for an independent mediator can also link with the category of a wish for additional spiritual support, in the sense that participants verbalised a need to debrief or to verbalise their experiences at work with an independent individual.

Four categories were discussed regarding the theme of supporting the mind as the cognitive and emotional dimension of the psychiatric nurse, including support in terms of empowerment from information sharing, support in terms of appreciation shown by management, a wish for additional informal information sharing and a wish for an independent mediator.

The mind forms part of the internal environment of an individual, along with dimensions of body and spirit (University of Johannesburg, 2009:5). The following theme that forms part of the internal environment, namely supporting the spirit as the relationship and conscience dimension of the psychiatric nurse, will be discussed next.

3.3.3.3 Supporting the spirit as the relationship and conscience dimension of the psychiatric nurse

According to the Theory for Health Promotion in Nursing, the spirit consists of two dimensions, namely relationships and conscience, which are integrated and interrelated (University of Johannesburg, 2009:6). The Theory for Health Promotion in Nursing further defines conscience as that part of the individual that determines what is right and what is wrong relating to relationships or interactions between the individual and God, self or others.

The theme of supporting the spirit as the relationship and conscience dimension of the psychiatric nurse links with the category of supportive relationships with colleagues and the category of embracement of cultural differences. Supportive relationships with colleagues address the relationship dimension, and embracement of cultural differences addresses the conscience dimension. Categories that were identified during the discovery phases of this research were workplace support in terms of a dependable relationship with God and the sense of self-support of the psychiatric nurse as indicated by green leaves in the picture of the tree (Figure 3.1). The category that was identified in terms of a wish of participants during the dream phase was the wish for additional spiritual support from a pastoral counsellor, as indicated by a pink bud in the picture of the tree (Figure 3.1).

a) Discovery phase categories relating to the spirit of the psychiatric nurse

Two categories were identified as a result of the discovery phase of this research that relate to the theme of supporting the spirit as the relationship and conscience dimension of the psychiatric nurse, namely support in terms of a dependable relationship with God and the sense of self-support of the psychiatric nurse.

a.i) Support in terms of a dependable relationship with God

It was clear that some of the participants felt a strong sense of support from their relationship with God. A dependable relationship can be described as a reliable and constant

relationship. Participants viewed their faith as supportive or as a coping strategy, linking this category with the next category of the sense of self-support of the psychiatric nurse. An individual interview with a manager revealed the following belief:

"Yes, I am a strong believer in our Creator, so I pray everyday that my dreams and wishes come true and only He knows what the future holds for us."

This belief was shared by yet another manager with whom I conducted an individual interview.

"I do not think that anybody can do this job without being a believer. God is my strongest support, He is everything. Even, uhm, in any nursing, I do not think you can do it if you do not believe."

Mohr (2006:177) however cautions that individuals, who are religiously preoccupied, might be isolated from other individuals who do not experience the same beliefs. Psychiatric nurses in this setting however, shared their religious faith and felt supported by, as well as a sense of belonging with, the other believers. This understanding of psychiatric nurses was evident when a participant commented as follows on spiritual involvement during a discovery phase feedback:

"It is not overly there, we are just all off Christian orientation and we all believe in a greater Being. It is not over extended. That person would have a professional ethic to work … the professional work ethic and also those respect for the individual."

Mohr (2006:175) writes that spirituality can be explained as the belief of an individual in or experience of a relationship of a power separate from the existence of the individual. Spirituality can also mean the "search for meaning" of an individual (Brown & Williams cited in Mohr, 2006:175). Spirituality thus consists of activities and beliefs in order for an individual to relate to God (Mohr, 2006:175).

Mohr (2006:176) examined the connection between mental health and religion, concluding that religion improved mental health and the better managing of stressful situations. Yoder-Wise (2011:560) suggests seeking "solace in prayer" or using meditation as a spiritual means to manage stress.

A category that links strongly with support in terms of a dependable relationship with God under the theme of supporting the spirit as the relationship, including the relationship with one self, and conscience dimension of the psychiatric nurse, is the sense of self-support of the psychiatric nurse.

a.ii) The psychiatric nurse' sense of self support

Participants experienced a sense of self-support, including knowing when to ask for assistance in terms of off-duty or support in their wards. The following dialogue transpired during the feedback phase of a small core group inquiry:

Discussion leader: *"There is a sense of self-awareness, you know yourself."*

Participant: *"Very much."*

Discussion leader: *"What I am also pick up from you, is a sense of self support. You realised that you were really tired, and you needed time out, so internally it also sounded as if you support yourself by being self-aware and feeling safe enough to voice and they* (members from nursing management) *were flexible."*

Participant: *"You do not need to say you are superwoman. You do not need to pretend. You can just be human."*

Participants used humour as a way of providing self-support, as reflected during the core group inquiries and illustrated by this participant:

"And the nice thing is if a situation like that (stressful situation in the ward) *occurred, that pop up, we had an informal way, and afterwards we will do the joke thing. The jokes absolutely releases tension, we have the same sense of humour."*

The sense of self-support of psychiatric nurses can be linked to workplace support in the sense that they are aware when they need support, when to ask for time off or when to ask for help. Psychiatric nurses working at this mental health care setting were also aware of the strengths and limitations of each other and they were available to augment each other.

Manion (2009:142) describes a workplace filled with fun, humour and different committees

that have responsibilities to organise fun events or socials for their colleagues, which connects to the theme of supporting the social environment of the psychiatric nurse, which I will discuss in paragraph 3.3.4.2.

Jackson et al. (2007:6) suggested several self-development actions to facilitate the resilience of individuals in the workplace. This includes the building of positive professional interactions, being positive, experiencing emotional insight, achieving balance and becoming reflective. This enthusiasm reflects the sense of self-support of the psychiatric nurse under the theme of supporting the spirit of the psychiatric nurse.

This can also be summarised by the positive principle of Appreciative Inquiry which states that change requires social bonding and positive affect (Whitney & Trosten-Bloom, 2003:54), which again correlates with the identified categories of supportive relationships with colleagues. Psychiatric nurses experienced support from colleagues, which enhanced the professional bond they shared. An additional assumption of Appreciative Inquiry states that "what we focus on becomes our reality" (Reed, 2007:27), meaning that having a sense of self-support can lead to resilience or enthusiasm in the psychiatric nurse.

b) Dream phase categories relating to supporting the spirit of the psychiatric nurse

One theme were identified as a result of the dream phase of this research that relates to the theme of supporting the spirit as the relationship and conscience dimension of the psychiatric nurse, namely a wish for additional spiritual support.

b.i) Wish for additional spiritual support

The wish for additional spiritual support as part of workplace support was verbalised as follows by a participant during the dream phase of a core group inquiry:

"I said maybe something like a, uhm, pastoral counsellor, that is also here on a daily basis ... for the staff as well."

Although only one participant verbalised a wish for additional spiritual support during one of the small core group inquiries, the nominal group technique produced two "votes" for this category, indicating that another participant also felt a need for additional spiritual support.

Sadock and Sadock (2007:6) show how religious beliefs and prayer might have a positive influence on the physical and mental health of an individual and suggests using a theologian when addressing spiritual themes. This correlates with the findings in this research. This category can also link with the category of a wish for an independent mediator, in the sense that participants felt the need to debrief or to verbalise their needs to an independent individual like a counsellor or a mediator.

The conclusion of a study performed by Ray and McGee (2006:336) is that "spirituality is important to" psychiatric nurses and "intervention strategies which offer spiritual support should be initiated at times of known stress", increasing the "quality of the work environment". Sun et al. (2006:91) state that spirituality is "something ideal, in that in one sense it is part of ourselves, part of our human inheritance … and in another sense it is not ourselves", producing energy and healing.

Three themes that relate to the internal environment were discussed, namely supporting the body, supporting the mind and supporting the spirit of psychiatric nurses relating to workplace support.

The following section contains a discussion of the external environment of the psychiatric nurse relating to workplace support and will include supporting the spiritual environment, supporting the social environment and supporting the physical environment of the psychiatric nurse. (See Figure 3.1, where the themes are represented by branches, the discovery phase categories by green leaves and the dream phase categories by pink buds.)

3.3.4 External environment of the psychiatric nurse

There are three themes that describe the external environment of the psychiatric nurse, namely supporting the physical, social and spiritual environment of the psychiatric nurse.
I will discuss each theme of the external environment followed by the various categories, divided into discovery and dream phase categories. The discovery phase categories are represented by green leaves and the dream phase categories are represented by pink buds in the figure (Figure 3.1).

3.3.4.1 Supporting the physical environment of the psychiatric nurse

The physical environment refers to physical or chemical structures and agents in the

external environment (University of Johannesburg, 2009:6). Support in terms of the physical environment of the psychiatric nurse includes categories of support in terms of an excellent working environment and effective systems from the discovery phases.

The dream phase led to the identification of two categories, namely a wish for an improved therapeutic environment and a wish to use systems more effectively.

a) Discovery phase categories relating to supporting the physical environment of the psychiatric nurse

Two categories were identified that result from the discovery phase of this research and which relate to supporting the physical environment of the psychiatric nurse, namely support in terms of an excellent working environment and support in terms of effective systems.

a.i) Support in terms of an excellent working environment

The field notes reflected that the garden and the therapeutic environment were a constant theme that emerged throughout the small core group inquiries and the individual interviews with members of nursing management. Participants expressed their appreciation concerning the effort and care that senior management invested in the physical environment, and especially the garden, experiencing their physical working environment as relaxed, peaceful, therapeutic and beautiful. The very first remark of a participant during the first core group inquiry illustrates the importance of support in terms of the physical working environment:

"My first impression was the garden, arriving here, seeing doctor (name) *busy planting flowers, it immediately gives me a feeling of welcome. The peacefulness on seeing all those beautiful plants, shrubs and trees, gives a feeling of calmness which also leads to the fact of feeling secure a peaceful."*

Participants also verbalised the positive effect that the environment has in relation to working at night, which can also be linked to the theme of the physical environment and the category of excellent working environment. The following comment was made during a small core group inquiry:

"Relaxation thing I find it at night time when you sit outside in summertime sit outside and look at the stars and whatever, instead of in that little room stuck in that little room, it is really cold and frustrating in there, and if we can use the garden for its properties. We just need a little bit of privacy away from the patients."

During the second core group inquiry, a participant elaborated as follows on the environment during feedback:

"Look, we all said about the environment, it is always clean, uhm, it is comfortable. In your teatime, or breakfast time, you can go and sit outside, without being, sitting with the patients. You can isolate yourself. It is quiet outside. It is a friendly, warm environment. So, and then, you and your colleagues can go and sit there and you can debrief. It also helps a lot."

Manion (2009:112) stresses the importance of the physical surroundings of the work environment in experiencing positive emotions. Pleasant working conditions in the form of a "pleasant physical environment" can lead to increased retention of personnel (Manion, 2009:148). Edwards and Burnard (2003:196) also stress the importance of the physical environment for the well-being of psychiatric nurses. Positive emotions and well-being can facilitate the promotion of the mental health of psychiatric nurses.

The narratives of participants regarding the garden and the category of support in terms of an excellent working environment led to the creation of the tree, symbolising the experiences and wishes regarding workplace support by psychiatric nurses. This symbol of workplace support in the form of a tree is significant for the future of this mental health care setting regarding the provision of workplace support to psychiatric nurses. Participants inspired me to craft this tree by their narratives that expressed their experiences and wishes regarding workplace support, where the experiences of participants are symbolised by green leaves, indicating the positive from the past, and their wishes by pink buds, indicating their wishes for the future.

The importance of the experiences of participants from the past and their wishes for the future can be linked to two assumptions of Appreciative Inquiry. Reed (2007:28) defines these two assumptions of Appreciative Inquiry as follows: "People have more confidence to journey to the future (the unknown) when they carry forward parts of the past (the known)" and "If we carry parts of the past forward, they should be what is best about the past".

a.ii) Support in terms of effective systems

Systems are all the mechanisms that are implemented at this mental health care setting to function effectively with the different services or processes that are employed in order to provide care for the mental health care users, such as admission procedures, administering of medication, record-keeping methods, protocols, communication lines in the hierarchy, grievance procedures, functioning and communication between support staff like occupational therapy, the kitchen, housekeeping, maintenance and security.

An individual interview with a member of nursing management revealed the confidence in the effectiveness of the systems employed at this mental health care setting.

"The fact that I trust the senior staff and that our documents and systems are in order also makes me feel more at ease."

Information gained during another individual interview revealed the same confidence in the effectiveness of the systems employed.

"The (senior management)*, I will go to them with problems, but not to the others. We have good protocols that work, and also the hospital rules. Also, uhm, the OT* (occupational therapy)*, we have good relations with them. I know everything at OT is correct and functioning and in good hands, uhm, the fact that we feel like a family and that we have been through terrible experiences together. My colleague (name) is always very supportive, and always listens."*

Narratives from participants participating in the small core group inquiries revealed the same appreciation of the effectiveness of the systems at this mental health care setting.

"I think we also just mentioned that the senior (nursing) *staff do come in and do support us in the water* (in the ward situation)*. When there is a difficult situation, they will come in and help you out. Sometimes they do find accommodation for you. They will come in and see this is a really stressful ward and you really had your share of it. They will give you somebody that is supportive or they will give you agency staff. I found myself, on working nights that you really get frustrated. The time we have, working for two days and then you have a break is that at nights it's really is there it I think there night matrons and senior staff might pick up and give you support."*

"The other thing is, uhm, the chief professional nurse, they took her out off the ward. And so, uhm, if you've got a crisis in your ward or a patient is difficult, or you've got a situation that you do not know how to handle, you can always phone her, and she will come to the ward, and help the sister with the situation, the crisis. It takes a lot of workload and conflict management off the sister in the ward, if she does not know how to handle it. The chief professional nurse will always come and help you with whatever. So it is supported on all levels. Yes, she has her cell phone with her and you can reach her anytime."

"We also have the extra care worker during the day, we call her the runner. She, uhm, she goes to each ward and collect the prescription from and take it to the pharmacy that also helps the sister. Especially when you are busy in the ward, you do not always have the time to go to the pharmacy, to fetch your medicine and continue with treatment. Now you can give it to the runner, she can take it and you can handle the crisis in the ward. It is so, it is like, and it makes it easier for us. It spares you that extra time to go out of the ward."

Participants expressed their appreciation for the functioning and communication between psychiatric nurses and the support staff as follows:

"We have actually talked about the rest of the staff, the people who do the maintenance, the cleaners, housekeeper; they are all supportive, very positive. Uhm, if you call them they will come immediately, it is not as if the work stays and you wait for a few days."

"Well, I think it makes, say the cupboard is broken, if you call someone, like maintenance it gets done, it is a positive attitude again towards the patients. Otherwise the patient gets agitated they feel like things get done and that gets reflected to you, you got it done, so it contributes to the whole positive attitude."

Participants also experience support in terms of the nursing management and administration, as is evident in the following narratives:

"Okay, we started with the matrons. They do regular daily rounds. There are weekly rounds also, but that is once a week on Wednesdays. The (senior management) and *one of the psychiatrists do weekly rounds in the wards. It is the same, they are caring, they are very caring, and they will ask how are you, and so, and also if there are problems, uhm, it's very supportive because I did not say that now, now, but if you've got a problem, it is not that you just say that they will do something about it. And it will be like the next day, because I*

wanted a board, net 'n bord (just a board)*, in the ward, and the next day they attended to it, so you feel like that they hear what you are saying."*

Psychiatric nurses reported confidence in the administrative personnel during the discovery phases of the core group inquiries.

"The admin. We have talked about the admin staff, they are also very capable, and the way they handled the patient. It is always kind of awkward for the patient to come, it is a new experience, and they (admin personnel) *handle them* (mental health care users) *well right from the beginning. They* (mental health care users) *are also less stressed when they come in the ward, which helps you and makes your work easier."*

Psychiatric nurses also experienced the system that was employed to order medication from the pharmacy as being effective and supportive.

"Yes, uhm, it is like for instance if a doctor prescribed medication, like we've got a crisis now with (meds name)*, it is not in stock. The pharmacist will phone the doctor, the psychiatrist, and say it is not available at the moment is there any other medication that we can give to the patient in the place off the* (meds name)*. So it is not necessary for us in the wards to phone the psychiatrist's, and says well, the pharmacist said it is not in stock, what can we give the patient? And, we also talked about when a person is got a problem; it is not always work-related."*

Systemic understanding of employees refer to their understanding of the purpose, functioning, parts, location and responsible individual of each service, as well as their understanding of the manner in which to function together or how to navigate in these systems (Bowles & Jones, 2005:285-286). It was clear that participants experienced understanding of the functioning of the existing systems and verbalised that they viewed the effectiveness of systems as being supportive.

Bowles and Jones (2005:288) state that collective decision-making and shared assessment are essential elements in reducing workplace anxiety. Whitney and Trosten- Bloom (2003:55) affirm this with the free-choice principle from Appreciative Inquiry that reveals how individual performance can be improved by letting individuals choose what and how to contribute. This can also be linked to the assumption in the Theory for Health Promotion in Nursing that stresses the mutual involvement between the patient and the nurse (University

of Johannesburg, 2009:4), or between the management of this mental health care setting and psychiatric nurses. Anxiety may influence coping and adjustment that link to mental health. When workplace anxiety is reduced, the mental health of psychiatric nurses may be promoted.

The category of support in terms of effective systems can also be linked to the categories of supportive relationships with colleagues, recognition of expertise by the multi-disciplinary team, embracement of cultural diversities and support in terms of empowerment by means of information sharing.

Effective systems respond to uncertainty and transformation in order to maintain homeostasis; in other words, all the processes are in place (Bowles & Jones, 2005:283, 288). Despite the positive experience of support in terms of effective systems that was shared during the discovery phase of this research, participants verbalised a wish to use systems even more effectively during the dream phase of this research. This might indicate a need to transform certain systems at this mental health care setting. The category of a wish to use systems more effectively will be discussed under b.ii.

b) Dream phase categories relating to supporting the physical environment of the psychiatric nurse

Two categories were identified as a result of the dream phase of this research relating to the theme of supporting the physical environment of the psychiatric nurse, namely a wish for an improved therapeutic environment and a wish to use systems more effectively.

b.i) Wish for an improved therapeutic environment

Despite all the positive elements regarding the environment that surfaced during the discovery phases, participants verbalised their wish for an improved and more therapeutic environment for psychiatric nurses.

The following comment was made after a dream phase during one of the small core group inquiries:

"Yes, and a therapeutic environment for the staff as well. We have a very nice environment, we have a tearoom so we can't complain but if we can make it a little bit more warm and

inviting and a place where you can talk. The tearoom is really freezing, so nobody wants to be there. And what we have is the splitting, some of the staff will sit there, and others will sit in the sun, and you have the splitting. The clicks if you can call it that. That team versus that team. The garden is a positive thing if we can split it off from, a little bit of the garden for ourselves."

There is an increased chance of employee retention if the work environment is positive, "creating a homey atmosphere means doing away with features like … standard institutional decorating schemes" and an ability to access the outdoors (Manion, 2009:365-366). Creating a relaxed atmosphere in which psychiatric nurses can sit in the garden may increase their sense of belonging and commitment to the mental health care setting. The quality of a health care environment can influence the services and provide positive outcomes like job satisfaction (Lavoie-Tremblay, Paquet, Duchesne, Santo, Gavrancic, Courcy & Gagnon, 2010:415). Dickens, Sugarman and Rogers (2005:300) also indicated the importance of the physical working environment and physical comfort for health care provision and for the nurses' perspective of work stress.

b.ii) Wish to utilise systems more effectively

The wish for improved and more effective systems was evident during the dream phases of the core group inquiries where participants reflected on their wishes.

"If the systems are in place, it would support you tremendously … I also think the environment is it is important that everybody can get more involved in the environment and even the planning that we can get more involved in the planning parties that plans for the hospital in terms of the future, what is the hospitals plans in terms of the future, new wards, (renovations and additional buildings were in the planning phase) *solar electricity or further plans in terms of the electricity."*

Participants verbalised their need to be more involved in planning, while they simultaneously verbalised a need for nursing management to be more involved in the wards, interacting with the mental health care users to identify and solve possible problems or complaints.

"The higher ranked personnel can come in and they can go from patient to patient and ask how you are today, do you have any complaints? Are you happy are you okay in other words being helpful and supportive, help to identify problems, not taking your job away."

Adding to the wish for nursing management to be more involved in the wards with regard to the mental health care users, the need for improved communication with the multi-disciplinary team was verbalised by participants during the dream phase.

"Because there are not any doctor rounds like in big hospitals we do not do that. You miss out on that a bit, you do your work you get through the routine. Then the matrons will pop in once or twice just to see how you're doing your work, and it stops there that is that. They don't really talk to the patients the way we do. Then the other thing is I think that sometimes we get stuck with the non-nursing jobs. Uhm, we have the nursing things in the job description, and then we get stuck with complaints about of fixing toilets and stuff, and I think in the ward the systems is in place, there are maintenance, there is the kitchen staff, there is the laundry staff, the cleaning ladies, bla, bla. That's so if something would go wrong in the ward, you would get stuck."

The following narratives from the dream phase illustrate the wish of participants to streamline communication and interaction with the support staff.

"Or if there were easier access for the patients so that they can get to it, for example if they had a problem with the kitchen with a menu or the food, they can go and speak to the kitchen, identify the person. Or maintenance, the toilet is broken, or if I see that guy in the overall over there, I can go and speak to him, here is the book, I can just write in it, and the sister will go and give it to him. The maintenance comes regularly, and they will just read in the book. It releases us from dealing with the simple stuff. There are things that need to get fixed, we can't find the TV channel."

"Because the kitchen is not functioning, or is closed or has a lack of staff, it all boils down to the sister again because she is the closest to the patients. So it is the sister who will need to send food back many times and say look this is not a diabetic diet."

"And on night duty they should definitely be somebody uhm, on night duty that uhm, for this kind of thing (maintenance and kitchen) *that can be called."*

"It is different companies (catering company) *is not even part of* (hospital)*, and the same with the cleaning ladies, it is a different company. But, because we are the sister, we are the easiest to access. The patient goes like you have to sort out your staff, and it is not my staff. You can't go like, it is not my work, you can't say that. It is amazing how these small things*

can irritate the patients."

Another issue that was raised regarding systems was the wish for a separate teenager ward. At the time of my research, the mental health care setting was allowed to admit only a limited number of adolescences, who were treated in the other wards among the adults.

"Uhm, my biggest dream for this place is to have a separate ward for teenagers, and it must be in such a way that uhm, say for instance that that house that they have bought now, that they will develop that place, which is separate from the hospital."

"It would be best if you could separate teens, geriatrics and psychotics. Because that is mainly you're three problems in a, uhm, and this hospital everything is all mixed."

The topic of the adolescences led the participants in the discussion phase to suggest the evaluation of patients before admission, as well as a separate admission ward or just a room, from which to effectively place the mental health care user in a specific ward. Participants felt that this would lead to better service delivery as well as being supportive towards psychiatric nurses.

"Uhm, I could add to the different structures. It will also be very supportive if patients are placed in wards, if they are evaluated by skilled people. Even if it is the senior sister or the matron. We have talked about having an admission room."

"A person admitting those patients or a few people doing that during the day, admitting the patients. Every patient should be placed to do it correctly. To get more efficient information, because it sometimes happened that we do her staff nurses who will admit the patients, or at night. At at 11 o'clock that morning I realised that this patient is a diabetic, and psychotic. Because then I get time for this admission."

"To add on from that, maybe you can start and do acuity levels, you can do, because one or two psychotic patients and an elderly patient, will push your acuity level up, and you are going to need more trained staff, and we do not get it. We get two staff members and a care worker and that is that, if you are lucky it is somebody that is trained. And I'm not saying put everybody in the same ward, if you see that your acuity levels are normal. Make turns and rotate people … Put more people, with persons that are not so skilled, if you can access them in the front, as I say temporarily admission place, ward, what ever. And then after that

assessment you put them in the wards, and you can go on ... I can understand that the person in charge, who is looking at the placed holistically, cannot dump you with all the difficult ones, and somebody else will have a breeze of the day, you have to be realistic."

"You cannot make one ward just for the psychotic ones, or overload a specific team with all those ones. It is a difficult balance, we each come from stuff at home, our, maybe something happened like a death in the family, bla, bla, all of us have that. It is sometimes difficult to leave all of that at the door and then you come into the ward and there is a psychotic one, a demanding one, a paranoid one, and this and that. We try as the seniors and even the matrons to just dilute them. We try to give everybody a patient that is difficult, and not to dump all the difficult ones on one."

Improvement of the administration, and especially the cardex system, according to which psychiatric nurses have to describe the care given to the mental health care users, in writing, was also expressed during the dream phases of the core groups.

"We've also said the admin paper, we've got a lot of admin. Like make a system, we can only tick off that the patient had his medication, his meals, and we have extra space where we can write the emotional stuff. How is the patient emotionally, was he manic? Because in your cardex writing, your write things three times during the day. It also takes a lot of time to write the cardex."

"Everybody writes the cardex in a different way, but most of the time it is the same over and over and over. The only thing that that differs is the patient was anxious, or crying, that is the only difference. And if there was a crisis with the patient, otherwise it is the same."

"We have to write, or that is how I was learnt, the patient had their medication, you have two write that they eat, that they did not eat, three times a day. That they have seen the doctor and that the doctor changed the prescription or not. That is the only thing you had to write. All the other things you can put together, but there is no time. That is what worries me, if you write for 26 patients, you have to write all that stuff. There is no time to write about the emotional stuff of the patients, how is the patient emotionally. Okay, and there is rounds. There are two rounds during the day. You have to write where the patient was, is he okay. I think it gets sloppy actually."

Bowles and Jones (2005:283) argue that one cannot assume that individuals with different priorities and from different teams would prioritise the development of whole systems, when all the parts are in place, in order to work in balance. It seems, however, from the dreams of psychiatric nurses in this research that this is indeed what they envision in order to feel more supported. They wished for all the different teams or services to be more synchronised and effective than it already is, as can be seen from the discovery phase remarks regarding effective systems in the workplace. This includes the efficient working together with senior personnel, with the multi-disciplinary team, with housekeeping or the kitchen, with maintenance and security.

The collaboration of teams performing different services is essential to ensure that the logistical functioning of a mental health care setting is connected (Schoppmann & Lüthi, 2009:613), correlating with the findings in this research. Bowles and Jones (2005:284) explored the working of whole systems in acute psychiatry and explain how failure within the system, like an inappropriate admission process or lack in communication between members of the multi-disciplinary team regarding client discharge, can have an effect on the psychiatric nurses working in the wards. Bowles and Jones (2005:288) suggest collective decision-making, responsiveness and increased flexibility within all parts of the system in order to decrease anxiety.

The category of a wish to use systems more effectively can be linked to the categories of a wish for further flexible shifts, a wish for improved teamwork, a wish for increased acknowledgement by the multi-disciplinary team and a wish to incorporate alternative therapies.

Four categories were discussed regarding the theme of supporting the physical environment of the psychiatric nurse, namely support in terms of an excellent working environment, support in terms of effective systems, a wish for an improved therapeutic environment and a wish to use systems more effectively.

The physical environment forms part of the external environment of an individual, along with the social and spiritual dimensions (University of Johannesburg, 2009:5). The following theme that forms part of the external environment, namely supporting the social environment of the psychiatric nurse, will be discussed next.

3.3.4.2 Supporting the social environment of the psychiatric nurse

The social environment of the psychiatric nurse refers to the "human resources in the external environment of the individual" (University of Johannesburg, 2009:7). I discussed workplace support in terms of the social environment of the psychiatric nurse under the categories supportive relationships with colleagues and the recognition of expertise by the multi-disciplinary team for the discovery phases and a wish for improved teamwork and a wish for increased acknowledgement by the multi-disciplinary team for the dream phases.

a) Discovery phase categories relating to supporting the social environment of the psychiatric nurse

Two categories were identified as a result of the discovery phase of this research on the theme of supporting the social environment of the psychiatric nurse, namely supportive relationships with colleagues and recognition of expertise by the multi-disciplinary team, as symbolised by green leaves on the tree. (See Figure 3.1.)

a.i) Supportive relationships with colleagues

The wholeness principle in Appreciative Inquiry was very dominant for me while exploring the experiences of the participants in this setting, due to the fact that the participants experienced teamwork and support and verbalised that they feel like a family. According to the wholeness principle, "wholeness brings out the best in people and organizations" (Whitney & Trosten-Bloom, 2003:55). I will provide some examples of what the participants shared with me during the core group inquiries and during the individual interviews that reflect their appreciation for the supportive relationships they experienced with their colleagues.

"(Members from middle and senior management) *are very supportive. They always listen and it is uhm, always confidential. You can tell them anything. I must say that between all the staff in the different wards there is always that unity if I feel that I can not deal with it, there is always this somebody that comes in and is somebody is knowledgeable."*

"If you are burnt out, you have to go on. That is important about psychiatric nurses, is that you could go to somebody and say I am fed up now. Can you take over my shift, or I am working on Sunday. I want the day off, would you be interested?"

"What I appreciate is the empathy of my colleagues. We like to help one another debriefing, especially when we have difficult patients. We have so much trust in each other and and we can talk to one another, and even phone one another, and debriefed about things."

The following extract from a completed naïve sketch indicates the emotional support experienced at work as well as the feeling of being like a family.

"I experienced a personal disappointment which I did not want to discuss at work. All my colleagues noticed that something was wrong, I told them everything, and everybody was very supportive. We feel like a family and we always support each other. I realised just how much we care for each other."

"It is still a small hospital. It is something special I do not think anyone will ever loose the significance; it can get a little bit too close for comfort. We have a great support system. It it is not like we work, anybody can pick up if you are having a bad day, or you are having some sort of stress. You do not have to know what (the problem is), *it is that just me being there and helping out in this situation."*

"Another thing that also gives support is that people will work with you that is an important factor for us, because like she's said, if you are in a situation that you can give over to us teenagers or whatever. You do not have to go in, that person has all the knowledge to deal with, with whatever. When people work with people there is not always the necessary training."

"Absolutely, but because we have this feeling of supporting one another, it gives you the kind off space to say like I am exhausted it is. And nobody is going to victimise you because you are saying I am exhausted."

"Uhm, but we usually do, especially on Sunday, uhm, we, everybody brings some money and we buy some cake. Like in the tearoom, everybody sit down and we debrief. Like at home, something happening in the ward. It can be personal; it can be work-related. We all just sit there and debrief. And it helps a lot."

"Yes, you are not just a number, you are a person. It is not like the big hospitals, like it is the sister that is working in the maternity ward. Here we knew that it is (name) *that this working in ward A, it is* (name) *working in ward E. We call each other by name, it is not always sister*

(name) *or sister* (name). *We feel comfortable to address each other on the name, and we feel comfortable with that. And we always greet each other, it does not matter if it is a doctor, or uhm, the superintendent, or the manager, we feel comfortable. And if we see each other, we greet each other, how are you. It is not like you walk past each other and you don't know who that is."*

Collaboration or teamwork means that individuals work together in order to realise a common objective, including enthusiasm to combine forces and the accepting of assistance from others (Bégat, et al. 2005:228). Teamwork implies unselfishness and kindness; thus sharing can enable individuals to identify their own limits as well as their own possibilities, as well as to appreciate the complete goal rather than only parts thereof (Bégat, et al. 2005:228). Manion (2009:175) shows that the central elements of a healthy work relationship are communication, trust and respect. Participants valued the relationships that they had with their colleagues, experiencing support in the workplace, as evidenced by the narratives of the participants.

Torp (2008:264) noted that social support received from managers and colleagues is clearly associated with a positive health and safety philosophy in a organisation, while absenteeism was associated with low social support at work (Griep, Rotenberg, Chor, Toivanen & Landsbergis, 2010:186).

Social support from colleagues has been shown to have a positive influence on work satisfaction among nurses (Craft Morgan & Lynn, 2009:407). Spence Laschinger *et al.* (2009:308) demonstrated the positive effect of working with colleagues where mutual respect is evident in their daily work. Newton, Kelly, Kremser, Jolly and Billett (2009:393) suggest that interaction with colleagues can produce more enjoyment and interest, which can increase work motivation. This correlates with the findings in this research.

The category of a supportive relationship with colleagues links with the next category of recognition of expertise by the multi-disciplinary team.

a.ii) Recognition of expertise by the multi-disciplinary team

During the individual interview, one of the middle nursing managers reported on her appreciation of the fact that she felt recognised by members of the multi-disciplinary team.

"I feel trusted by them and very professional. They address me respectful and I feel that I can have a different opinion and they will respect me, and value my input. Yes, when I maybe suggest that a patient receives ECT, it worked and the doctor told me my expertise is good and it boosted my self-confidence. If you are in the wrong, they will show you the right way. Yes, I feel part of a team."

This feeling of being appreciated for one's expertise and skills by members of the multi-disciplinary team was not only limited to members of middle nursing management, but psychiatric nurses verbalised the same opinion during the core group inquiries, relating to psychiatrists and psychologists.

"Also with the medicine I found, I had the opportunity, I had the freedom of speech I felt I could tell the doctor, and this medication does not work with the patient. And he did not see it that I was barging into on his territory, which I appreciate that. He prescribes it, but we all want to see that it works because we are seven days 12 hour with this patient."

The appreciation of unique expertise and skills was also verbalised regarding the occupational therapists.

"Yes they will come and listen if the patient is in the ward and they are available if you want to speak to them about a certain patient if a certain patient needs more intensive care or what ever. So the occupational therapist and they've got a positive attitude all of them."

Meetings between multi disciplinary team members serve several functions, namely, to exchange information, to coordinate duties, to reflect on diagnosis and therapies and to make suggestions (Schoppmann, 2009:610). Searl (2007:172-173) discusses this relationship between a physician and the nurse, explaining that the relationship is "a collegial one between two practitioners who are both responsible for the patient".

Seed, Torkelson and Alnatour (2010:168) show how psychiatric nurses "rated high satisfaction" when they participated in communication with the multi-disciplinary health team. This communication and "supportive relationship" (Seed *et al.,* 2010:168) between psychiatric nurses and other members of the multi-disciplinary team indicate reciprocal recognition of expertise, correlating with the findings in this research.

Hanrahan et al. (2010:204) stress the importance of strong multi disciplinary relations when

working with complex and integrated psychological and physical conditions in clients in a mental health care setting. Sun et al. (2006:90) stress the importance of all members of the multi disciplinary team voicing their professional thoughts in order to provide optimal care for the mental health care users, entailing mutual respect and trust in each professional's unique skills, knowledge and qualities.

b) Dream phase categories relating to supporting the social environment of the psychiatric nurse

Two categories were identified as a result of the dream phase of this research relating to the theme of supporting the social environment of the psychiatric nurse, namely a wish for improved teamwork and a wish for increased acknowledgement by the multi-disciplinary team, as symbolised by pink buds on the tree. (See Figure 3.1.)

b.i) Wish for improved teamwork

Teamwork in this context can be described as shared responsibility for decision-making, sincerity and flexibility among psychiatric nurses working together, as well as with the other nursing staff, the multi-disciplinary team and support staff. In an interview with one of the managers, the following was said relating to a wish for improved teamwork:

"Human relations are very important to me, and I would like to incorporate that more. I would like to focus more on people, on staff, and not only on work. I would arrange more socials and interactions on my shift do more nice things."

A participant who worked night duty verbalised the wish for improved teamwork, referring to communication between the day staff and the night staff, during a small core group inquiry as follows:

"That is the difference between day and night, we felt that we are the stepchildren at night."

A wish for improved teamwork transpired during the following dialogue between the researcher and a member from nursing management, referring to feeling involved in decisions and clear communication between team members.

Researcher: *"So, you would like to feel more involved in decisions and you would also like a clear explanation of what is expected of you?"*

Participant: *"Yes."*

Bowles and Jones (2005:288) report that the stress experienced by employees can be managed by collective teamwork, shared decision-making, flexibility and openness. Effective teamwork involves a sense of community and increases the emotional bond between employees and between employees and leaders, thus enhancing commitment (Manion, 2009:193). The category of a wish for improved teamwork can be linked to the category of a wish for increased acknowledgement by the multi-disciplinary team.

b.ii) Wish for increased acknowledgement by the multi disciplinary team

There is a wish for more multi-disciplinary interaction and acknowledgement, as can be seen by the following comments from a discussion after the dream phase from the core group inquiry:

"They are not always here, the sister can phone me and tell me, but the time is not there to do that, it is the ideal. We would like to get all the guys (multi-disciplinary team members) *together and discuss the patients."*

"We said that uhm, to get something, those that they have at the state hospitals, like the multi disciplinary team panels, just to get every body involved, the doctors don't see the patients like we see them, they see them for that 20, 25 minutes, and everything is rosy and fine they do not see their odd behaviour or funny things that we see. The same goes with the occupational therapy."

Uys (2004:37) describe how the role of the psychiatric nurse overlaps with that of other members from the multi-disciplinary team, meaning that similar knowledge and skills are used, but emphasises the role of the psychiatric nurse as more encompassing than that of other professions. This is also evident in the Theory for Health Promotion in Nursing, which defines the role of the nurse as a therapeutic, sensitive professional who demonstrates skills, values and knowledge in the facilitation of health promotion (University of Johannesburg, 2009:4).

Four categories were discussed regarding the theme of supporting the social environment of the psychiatric nurse, namely supportive relationships with colleagues, recognition of expertise by the multi-disciplinary team, a wish for improved teamwork and a wish for increased acknowledgement by the multi-disciplinary team. The social environment forms part of the external environment of an individual, along with the physical and spiritual dimensions (University of Johannesburg, 2009:5). The following theme that forms part of the external environment, namely supporting the spiritual environment of the psychiatric nurse, will be discussed next.

3.3.4.3 Supporting the spiritual environment of the psychiatric nurse

The spiritual environment refers to the religious aspects and the values in the external environment of the individual (University of Johannesburg, 2009:7). The categories embracement of cultural diversities and the acceptance of social responsibilities, stemming from the values in the external environment, emerged during the discovery phases of the small core group inquiries. A wish to incorporate alternative therapies was a category that emerged during the dream phase of the small core group inquiries.

a) Discovery phase categories relating to supporting the spiritual environment of the psychiatric nurse

Two categories were identified resulting from the discovery phase of this research relating to the theme of supporting the spiritual environment of the psychiatric nurse, namely embracement of cultural diversities and acceptance of social responsibilities.

a.i) Embracement of cultural diversities

Havens et al. (2006:468) explain how the concepts of cultural awareness, involvement, collaboration and communication are interrelated and dynamic and suggest using Appreciative Inquiry to examine these concepts. An embracement of cultural diversities is a reflection of values, relating to the spiritual dimension of an individual.

The cultural awareness and embracement of cultural diversities by psychiatric nurses are evident from remarks made during the core group inquiries.

"Although we have different cultures in staff centre, we try to accommodate one another as much as possible."

"Yes, cultural wise there is differences we are getting to support each other's culture we are getting more and more comfortable with each other's cultures."

"Yes, we mentioned about the staff nurses that is very positive we talked a little bit about the culture, because most of them is black. They have a positive attitude towards us, and they are well trained. They are capable, they can take over a ward, and the care workers also, the staff nurses and the care workers."

Diversity of race, gender, religion and culture is a characteristic of the South African work environment and managing systems can only be effective if these differences and values are respected (Schreuder & Coetzee, 2010:11). Schreuder and Coetzee (2010:12) continue to argue that although differences can lead to conflict, it can also build sensitivity towards different individuals and groups, leading to a collective cross-fertilisation of richness and variety. This correlates with the findings in this research.

Yoder-Wise (2011:166) discusses three principles relating to the embracement of cultural diversities, which include multi-culturalism as maintaining different cultures, cross-culturalism as mediating between cultures and trans-culturalism as bridging differences in cultural practices. Managers should build a new knowledge base with regard to cultural differences by motivating employees to attend cultural educational sessions (Yoder-Wise, 2011:169). Different cultures were maintained in the mental health care setting and psychiatric nurses practised trans-culturalism by accepting and acknowledging the different cultures in the workplace.

Mohr (2006:178) implores nurses to be aware of and to examine their own values in order to discover what is important to other individuals; thus self-awareness and value clarification are combined. Self-awareness permits nurses to continue from their own cultural or spiritual perspectives without imposing on others (Mohr, 2006:178). Participants verbalised examples of accommodating behaviour, being committed to learning about other cultures and of being comfortable with cultural diversities.

In research on work environments and attitudes in mental health care settings, Lesinskiene et al. (2007:761) propose that in-service training and information sharing be presented in

native languages. Cultural awareness involves education and the gathering of information in order to examine biases, to be sensitive and understanding and to understand different perspectives (Ndiwane, Miller, Bonner, Imperio, Matzo, McNeal, Amertil & Feldman, 2004:119).

Two assumption of Appreciative Inquiry can be linked to the category of embracement of cultural differences, namely "it is important to value differences" and "there are multiple realities" (Reed, 2007:28).

The category of embracement of cultural diversities can be linked to the categories of supportive relationships with colleagues and acceptance of social responsibilities, as well as with a wish to incorporate alternative therapies, which will be discussed under b.i.

a.ii) Acceptance of social responsibilities

During one of the individual interviews, a member of the nursing management verbalised how management at this mental health care setting accepted their social responsibilities by the implementation of programmes aimed at disadvantaged communities.

"The government expects my company, uhm, my hospital to be involved in programmes, uhm, like reach out programmes, to uplift disadvantaged neighbouring communities and I identified a home in (name) *which is approximately twenty five kilometres from us. My supervisors welcomed the idea, and up to this stage, I am the coordinator thereof. The name of the home is* (name) *home base care which is catering for poor families, orphans and HIV positive people making use of volunteers."*

Searle (2007:38) emphasises the importance for nurses to accept their social responsibilities. The acknowledgement of their social responsibilities by members of management of this mental health care setting emphasises their commitment to providing support, not only to their employees, but to the community as well.

The acceptance of social responsibilities is also a reflection of the values, as part of the spiritual dimension of the external environment, of the management (hospital management and nursing management) at this mental health care setting.

I could not locate relevant articles pertaining to the category of acceptance of social responsibilities in an acute mental health care setting, by using social responsibilities, social support or community involvement as keywords on the CINAHL or OVID databases.

This could be attributed to the fact that all relevant information pertaining to the social responsibilities of psychiatric nurses is relevant to community psychiatric nurses and could not be generalised to an acute mental health care setting.

b) Dream phase category relating to supporting the spiritual environment of the psychiatric nurse

One category was identified as a result of the dream phase of this research relating to the theme of supporting the spiritual environment of the psychiatric nurse, namely a wish to incorporate alternative therapies.

b.i) Wish to incorporate alternative therapies

Participants used the phrase alternative therapies to describe complementary and alternative medicine, which can be linked to the spiritual dimension in the external environment of the individual. Complementary medicines that are already used in conjunction with the conventional treatment at this mental health care setting include homeopathic medicine, naturopathic medicine, hypnosis, art therapy, music therapy, visual imagery, relaxation, special diets and dietary supplements. Complementary medicines that are not yet available at this mental health care setting include yoga, biofeedback, chiropractic manipulation, massage, healing touch, reiki, bio-electromagnetic-based therapies, colour therapies and light therapies (Kneisl & Trigoboff, 2009:873).

Participants verbalised the desire to incorporate alternative therapies as a wish during one of the dream phases of the core group inquiries.

"Another thing that I think would be good is alternative therapies, more than the existing ones here like anything you would like to bring in there are lots of new methods, of treatment, new therapies."

"There are new things that develop like light therapy, colour therapy, there are a lot of new things in the world but it would be a leading hospital if we could take things like that."

Kneisl and Trigoboff (2009:872) define complementary therapy as therapy that is used together with conventional medical therapy and alternative therapy as therapy that is used instead of conventional medical therapy. Nursing that is aimed at providing holistic care (University of Johannesburg, 2009:4) is especially suited to provide integrative therapy (Kneisl & Trigoboff, 2009:872).

The experiences and wishes of psychiatric nurses regarding workplace support at this mental health care setting were discussed by referring to the internal environment and the external environment. The internal environment consisted of three themes, symbolised by branches, namely supporting the body, supporting the mind and supporting the spirit of the psychiatric nurse. The external environment consisted of three themes, symbolised by branches, namely supporting the physical environment, supporting the social environment and supporting the spiritual environment of the psychiatric nurse. The discovery phase categories (green leaves) were discussed under each theme, along with the dream phase categories (pink buds). (See Figure 3.1.)

3.4 CONCLUSION

In this chapter, I identified the central storyline, the themes and categories that emerged from the naïve sketches during my data analysis, the core group inquiries and the individual interviews with members of management. These identified themes correlated with the Theory for Health Promotion in Nursing and were linked to the assumptions of Appreciative Inquiry.

The experiences of participants regarding the Appreciative Inquiry process were noted in the field notes, as feedback from them, after the conclusion of the two small core group inquiries.

"I became aware of strengths and weaknesses, realising that I can come up with solutions. I also realised that I can influence people positively."

"It was a good experience. I learned to be positive. I appreciated the structuring and the reflecting on the dream"

"I can return to my environment and make positive contributions"

As discussed in section 3.3.1, central storyline, pruning the tree symbolised transformation and a potential for growth with regard to workplace support for psychiatric nurses working at this mental health care setting. Participants kept referring to the willingness of management to provide workplace support during the discovery phase of this research, thus forming the roots of the tree that represented workplace support.

The central theme that emerged, the trunk of the tree, and from which all the other themes developed, is a holistic approach to workplace support, connected to the holistic view in the Theory for Health Promotion in Nursing (University of Johannesburg, 2009:4).

The themes that emerged from the central theme of a holistic approach to workplace support can be divided into the internal environment and the external environment of the psychiatric nurse. Themes, or branches, that were included in the internal environment comprise supporting the body as the physical dimension, supporting the mind as the cognitive and emotional dimension and supporting the spirit as the relationship and conscience dimension of the psychiatric nurse. Themes, or branches, that were included in the external environment comprise supporting the physical environment, supporting the social environment and supporting the spiritual environment of the psychiatric nurse.

The discovery phases of the data collection process produced descriptions from psychiatric nurses regarding peak past experiences of workplace support, symbolised by green leaves. The dream phase of the data collection process produced wishes from psychiatric nurses regarding the facilitation of holistic workplace support, symbolised by pink buds. Recommendations made to the management of this mental health care setting (discussed in chapter 4) might lead to the facilitation of processes to provide psychiatric nurses with holistic workplace support in order to facilitate the promotion of their mental health.

In chapter 3 each theme and category that were identified regarding workplace support were discussed individually, together with a literature control in order to substantiate the findings. I also provided verbatim examples from the original transcribed data to verify the findings.

CHAPTER 4

JUSTIFICATION, LIMITATIONS, CONCLUSIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

In the final chapter, I will discuss the justification and the limitations with regard to the research design and the research methods of this research. I will discuss the conclusions and finally I will propose recommendations that emerged from the findings by referring to psychiatric nursing research, psychiatric nursing education, psychiatric nursing management and psychiatric nursing practice.

4.2 JUSTIFICATION OF THIS RESEARCH

In the background and rationale of this research in chapter 1, I discussed the changing environment of health care and the need for the provision of workplace support to nurses. I discussed the unique challenges that face psychiatric nurses in a private mental health care setting, along with organisational and occupational stresses that can lead to burnout. The observation of signs of burnout in psychiatric nurses working at a private mental health care setting led me to the formulation of the research questions, namely what are the experiences of psychiatric nurses of workplace support in a private mental health care setting and what wishes could psychiatric nurses have regarding workplace support in a private mental health care setting?

This research questions were followed by the purpose of this research, namely to conduct an Appreciative Inquiry in order to generate an in-depth understanding of the experiences and wishes of psychiatric nurses regarding workplace support in order to propose recommendations that may contribute to the facilitation of the promotion of the mental health of psychiatric nurses in a private mental health care setting.

I identified three objectives for this research, namely to explore and describe the experience of psychiatric nurses of workplace support in a private mental health care setting, to explore and describe the wishes of psychiatric nurses regarding workplace support in a private mental health care setting and to propose recommendations regarding workplace support

with reference to psychiatric nursing research, psychiatric nursing education, psychiatric nursing management and psychiatric nursing practice, in order to facilitate more effective means to provide workplace support and to facilitate the promotion of the mental health of psychiatric nurses.

The meta-theoretical perspective that guided this research was the Theory for Health Promotion in Nursing, and the theoretical perspective that guided this research was Appreciative Inquiry. The research questions directed the research design (University of Johannesburg, 2009:10), namely a qualitative, exploratory, descriptive and contextual design that was used in order to generate the data about the experiences and wishes of psychiatric nurses regarding workplace support in a private mental health care setting. In chapter 3, a description was provided of the experiences and wishes of psychiatric nurses regarding workplace support in a private mental health care setting.

The question concerning the experiences and wishes of psychiatric nurses regarding workplace support in a private mental health care setting was relevant, as discussed in the background and rationale section in chapter 1. Participants demonstrated, during the discovery phase of Appreciative Inquiry, how a context experienced as providing workplace support could have a positive impact on the mental health of the psychiatric nurse.

I am proposing recommendations relating to psychiatric nursing research, psychiatric nursing education, psychiatric nursing management and psychiatric nursing practice in this chapter (see paragraph 4.5, recommendations). The aim of these recommendations is to facilitate more effective means of providing workplace support, in order to facilitate the promotion of the mental health of psychiatric nurses working at this mental health care setting. This research was thus justified, since the purpose and objectives, as stated in chapter 1, were achieved.

The use of the Theory for Health Promotion in Nursing and Appreciative Inquiry as meta-theoretical and theoretical perspectives can be justified with regard to the findings, which show a holistic approach to workplace support as the central theme, giving rise to themes regarding the internal environment and the external environment of the psychiatric nurse. Categories that emerged from these themes included experiences of support that were identified during the discovery phase and wishes that were identified during the dream phase.

Reed (2007:107) justifies the significance of an Appreciate Inquiry research by referring to the transformational nature of a discussion concerning peak past experiences. Reed (2007:107) also indicates how participants can be empowered by their engagement in the Appreciative Inquiry process. I experienced this potential for transformation and a feeling of empowerment from participants by being allowed to verbalise their experiences and wishes regarding workplace support during the small core group inquiries and the individual interviews with members of nursing management, as evidenced by the reflections of the participants regarding their positive experiences.

4.3 LIMITATIONS OF THIS RESEARCH

I will discuss the limitations of my research in terms of the research design and the research methods used.

4.3.1 Limitations of the research design

A qualitative design was used in this research, which was exploratory, descriptive and contextual, with an Appreciative Inquiry approach. A possible limitation of this research might be related to the contextual design that was used. I described the experiences and wishes regarding workplace support in a specific context, namely a private mental health care setting in Gauteng, and did not intend to make generalisations to other settings. The research findings can be limited in terms of the facilitation of workplace support in other private mental health care settings, as well as generalisations to mental health care settings in the public sector.

Participants might have felt that the process of Appreciative Inquiry was incomplete, due to the fact that I only implemented the first two stages of the 4-D cycle of Appreciative Inquiry, namely the discovery phase and the dream phase. The implementation of all these phases in the 4-D cycle might have left participants with a greater sense of completion, and I will strongly recommend the implementation of all four phases of the Appreciative Inquiry 4-D cycle later in this chapter under the recommendations. Reed (2007:124), however, provides examples of research that was done by using only the first two stages of the 4-D cycle of Appreciative Inquiry, namely the discovery phase and the dream phase. I was confident that the implementation of only the first two stages was sufficient to reach the objectives of this research and I discussed this in paragraph 1.5.2.1, Appreciative Inquiry.

4.3.2 Limitations of research methods

I will discuss the limitations of the research methods in terms of the sampling method, the data collection method and the data analysis method used.

4.3.2.1 Sampling method

Although I was confident that data saturation was achieved due to no new themes emerging, the research was conducted with a limited number of participants (10) due to the organisational size. I extended invitations to participate in this research to all possible participants and on an ongoing basis during the selection-of-participants phase, as discussed in paragraph 2.4.2.2.

Although there were 50 prospective participants, several prospective participants were not willing or unable to participate in the data collection phase of this research. Ten psychiatric nurses participated in this research, which might have limited the richness of the information obtained. Additionally I felt that the demographics of the participants were limited with regard to gender and race, as discussed in paragraph 2.6.6, justice, and that the participants who were willing and able to participate in the research were not a complete representation of the target population. The participants who were willing to participate in this research might have had different perspectives or might have been more positive than those participants who chose not to participate in this research.

Participation was voluntary, and some individuals with a rich source of information were not willing to participate in the research, although I gave information beforehand concerning the research and Appreciative Inquiry in order to motivate participation. This unwillingness to participate might stem from a lack of knowledge regarding research in general and Appreciative Inquiry in this context, or from negative previous experiences regarding research. A more extensive information session regarding research and Appreciative Inquiry, conducted before the inviting of participants, might have produced more willing participants.

4.3.2.2 Data collection method

My association with the participants might have influenced their openness during data collection. Although the participants seemingly felt comfortable with me as the researcher,

some themes might still not have been expressed. De Vos, Schulze and Patel (2005:6) speak of an "emphatic understanding" in the human sciences, but also emphasise that an important detachment of the researcher from the participants and information is necessary in order to keep away from emphasising her own partiality or dislikes (Strydom, 2005:248). I was very aware of my personal identification and possible subjectivity towards psychiatric nurses and the data obtained at this specific mental health care setting and reflected a lot on my impartiality in the field notes and during the recording of the positive core maps (addendum J) and the data analysis phase.

I also used an independent discussion leader to ensure richness of information. The discussion leader conducted a bracketing interview or reflective interview (addendum N) with me by after the first small core group inquiry. My supervisor, who acted as the discussion leader of the second small core group inquiry, again conducted such an interview with me after the second small core group inquiry. The purpose of these interviews was to create awareness of my own experiences regarding workplace support in this setting.

Confidentiality was difficult in a group setting, and the participants might have been hesitant to volunteer information. Participants were aware of the data collection methods before signing informed consent to participate in this research. I invited participants to contact me after the core group inquiries if they had anything else to add, but no participant contacted me, which indicated that participants shared their experiences and wishes during the group phase of the data collection.

I gave participants the opportunity to divide themselves into groups to make them feel more at ease during the one-on-one interviews between participants. The participants were all registered psychiatric nurses, competent in interview and communication skills, and interview schedules were provided containing the discovery and dream phase questions. I was present at all times to observe the one-on-one interviews between participants, to make field notes and to answer the questions of participants regarding the data collection process.

I only requested that participants in this research complete the naïve sketches. Participants who were willing to participate in this research might have had different or more positive views than those psychiatric nurses who did not participate in the research. I could have requested that all psychiatric nurses who were employed at this mental health care setting complete a naïve sketch, whether they participated in the small core group inquiries or not.

4.3.2.3 Data analysis method

This research involved several different data sources, namely written naïve sketches, completed interview schedules from participants, transcribed feedback from the feedback and discussion phase of the small core group inquiries, positive core maps and the results from the nominal group technique, field notes, transcriptions from the reflective interviews with the discussion leaders and transcriptions from the individual interviews with members of nursing management. The amount of different data sources was at times overwhelming, but the advantages of using several different data sources included achieving triangulation, confirmation of data saturation, ensuring reliability, ensuring validity and obtaining a thick description of the experiences and wishes of psychiatric nurses regarding workplace support at this mental health care setting.

There is a limitation regarding rich evidence in the form of the limited amount of quotes from participants provided in the final report. This can be attributed to the limited number of participants who participated in this research, as described earlier in paragraph 4.3.2.1, sampling method. I am, however, confident that data saturation was achieved, as no new themes emerged and themes were being repeated. The limited number of quotes provided can also be attributed to the number of themes and categories that were identified during the data analysis process, the nominal group technique and open coding.

There were one central theme, six themes and twenty-two categories identified and discussed in this research representing workplace support. A holistic approach to workplace support, which was the central theme, led to all the other themes and categories. The quotes that were provided in the final report under one category could also be descriptive of one or two other categories, thus emphasising the holistic approach to workplace support. I did indicate the relationship between themes and categories in chapter 3 where relevant.

Some of the categories that I have discussed in chapter 3 might lack rich evidence in the form of the quantity of literature references in order to re-contextualise the findings. I have used all the themes, categories, workplace support for psychiatric nurses and workplace support in a mental health care setting as key words on the CINAHL and OVID databases.

4.4 CONCLUSIONS

The research questions that were discussed in chapter 1 are stated below.

- What are the experiences of psychiatric nurses regarding workplace support in a private mental health care setting?

- What wishes could psychiatric nurses have regarding workplace support in a private mental health care setting?

The conclusion of this research is based on the findings discussed in chapter 3. I will discuss the conclusions referring to the research questions.

The first research question regarding the experiences of workplace support was addressed by using the naïve sketches, the discovery phase questions, the discovery phase feedback of the small core group inquiries and by using the discovery phase questions during the individual interviews conducted with members of nursing management. The discovery phase question gave rise to the description of a peak experience regarding workplace support and the acknowledgement of existing actions from colleagues or supervisors that participants experienced as being supportive, as symbolised by the green leaves of the tree. (See Figure 3.1.)

This experiences verbalised by psychiatric nurses were diverse (see chapter 3) and correlated with the Theory for Health Promotion in Nursing, indicating that participants experienced workplace support in their internal environment as supporting the body, mind and spirit of the psychiatric nurse and the external environment as supporting the physical, social and spiritual environment of the psychiatric nurse.

The second research question regarding the wishes of psychiatric nurses concerning workplace support was addressed during the dream phase questions, the dream phase feedback of the small core group inquiries and during the dream phase questions of the individual interviews conducted with members of nursing management. The dream phase question gave rise to the description of the wishes of participants in order to experience the best possible support at work, as symbolised by the pink buds of the tree. (See Figure 3.1.)

The wishes that were verbalised by psychiatric nurses were diverse (see chapter 3) and correlated with the Theory for Health Promotion in Nursing, indicating that participants wished for workplace support in their internal environment as supporting the body, mind and spirit of the psychiatric nurse and the external environment as supporting the physical, social and spiritual environment of the psychiatric nurse.

The use of the Appreciative Inquiry approach in this research, using the first two stages of the 4-D cycle, produced a thick description of the experiences and wishes of psychiatric nurses regarding workplace support, thus addressing the research questions. The research questions led to the formulation of the purpose and objectives of this research, as discussed in chapter 1.

The purpose of this research was to conduct an Appreciative Inquiry in order to generate an in-depth understanding of the experiences and wishes of psychiatric nurses regarding workplace support in a private mental health care setting.

The objectives of the research were to

- explore and describe the experiences of psychiatric nurses regarding workplace support in a private mental health care setting;

- explore and describe the wishes of psychiatric nurses regarding workplace support in a private mental health care setting; and

- propose recommendations regarding workplace support with reference to psychiatric nursing research, psychiatric nursing education, psychiatric nursing management and psychiatric nursing practice, in order to facilitate more effective means to provide workplace support and to facilitate the promotion of the mental health of psychiatric nurses.

Participants shared their narratives regarding their experiences of workplace support in the past and it had significant meaning to psychiatric nurses who participated. Participants verbalised that they “feel close” (to their colleagues) or “like a family”. Participants also verbalised the importance of the environment to them and a tree became the symbol of workplace support at this mental health care setting. The roots of the tree symbolised the willingness from members of management to provide workplace support to psychiatric nurses.

The trunk of the tree symbolised a holistic approach to workplace support. This holistic approach regarding workplace support has six branches correlating with the Theory for Health Promotion in Nursing. This branches or themes could be divided into the internal environment and the external environment of the psychiatric nurse regarding workplace

support. Themes representing the internal environment were supporting the body as the physical dimension, supporting the mind as the cognitive and emotional dimension and supporting the spirit as the relationship and conscience dimension of the psychiatric nurse. Themes representing the external environment were supporting the physical environment, supporting the social environment and supporting the spiritual environment of the psychiatric nurse regarding workplace support.

The experiences of psychiatric nurses regarding workplace support did not only focus on one or two aspects of workplace support, but were holistic, referring to their internal and external environments. The wishes of psychiatric nurses regarding workplace support did not focus on one or two aspects of workplace support either, but were also holistic, referring to their internal and external environments.

The assumptions of Appreciative Inquiry, stemming from the principles (discussed in paragraph 1.6.2.2) were also illustrated in this research. The constructionist principle, which can be linked to the contextual design used in this research, indicates how participants in this research constructed their own reality regarding workplace support through the stories that they conveyed. Regarding the simultaneity principle, participants already started to create change in this organisation and personally by reflecting on the subject of workplace support and by verbalising their wishes regarding workplace support. The poetic principle transpired through the production of a thick description regarding the experiences and wishes of psychiatric nurses regarding workplace support.

The anticipatory and positive principle emerged when participants imagined a positive future regarding workplace support in the dream phases of the data collection process. The wholeness principle was illustrated by the central theme of a holistic approach to workplace support.

The conclusion of workplace support as being holistic led me to formulate the recommendations stated in paragraph 4.5 for this research.

4.5 RECOMMENDATIONS

I will discuss the recommendations that emerged during my research on workplace support in terms of recommendations relating to psychiatric nursing research, psychiatric nursing education, psychiatric nursing management and psychiatric nursing practice.

The final objective of this research, namely to propose recommendations regarding workplace support with reference to psychiatric nursing research, psychiatric nursing education, psychiatric nursing management and psychiatric nursing practice in order to facilitate more effective means to provide workplace support and to facilitate the promotion of the mental health of psychiatric nurses, guided me to choose Appreciative Inquiry as research approach, specifically aimed at "process improvement" (Whitney & Trosten-Bloom, 2003:26).

4.5.1 Psychiatric nursing research

I recommend the application of an Appreciative Inquiry research approach in other mental health care settings that include public and private mental health care facilities to explore and describe workplace support in these contexts. The use of the 4-D cycle of Appreciative Inquiry is suited to support related research, due to the affirmative nature of Appreciative Inquiry. During the discovery phase participants "appreciate" (Whitney & Trosten-Bloom, 2003:6) existing facilitating factors, the dream phase provides an opportunity for participants to envision and verbalise their specific individual needs, the design phase can aid participants to distinguish between facilitating and restraining factors and the delivery phase can aid participants in the "mobilisation of resources" (University of Johannesburg, 2009:4), linking the Theory for Health Promotion in Nursing with Appreciative Inquiry. The combination of the Theory for Health Promotion in Nursing and Appreciative Inquiry as theoretical perspectives was shown to be complementary in this research.

Research can be done to explore the link between workplace support and the productivity of the psychiatric nurse. Another research might explore the connection between workplace support and job satisfaction of psychiatric nurses.

4.5.2 Psychiatric nursing education

After the implementation of Appreciative Inquiry as a research approach, I propose that research curricula include Appreciative Inquiry as a qualitative research approach. I further propose that advanced psychiatric nursing students be trained in the facilitation of an Appreciative Inquiry process due to the transformational nature of Appreciative Inquiry and the possible wide application of this theoretical perspective, as discussed in paragraph 4.5.1, psychiatric nursing research. "Individuals, families, groups and communities" (University of Johannesburg, 2009:5) can be transformed by using an Appreciative Inquiry approach, as

discussed in paragraph 4.5.1, psychiatric nursing research.

The importance of establishing a journal club in order to facilitate continuous education was evident from the participants in this research. I propose that psychiatric nursing education stresses the importance of the establishing of a journal club for the psychiatric nursing students, regardless of the environments in which they work, including education regarding the finding, evaluation, interpretation and communication of journal articles.

4.5.3 Psychiatric nursing management

Since I only used the first two phases of the 4-D cycle of Appreciative Inquiry, namely the discovery phase and the dream phase, I strongly recommend the facilitation of the entire 4-D cycle of Appreciative Inquiry (discovery phase, dream phase, design phase and destiny phase) regarding workplace support at this mental health care setting in future research. I also suggest to involve other nursing staff (enrolled nurses), members from the multi-disciplinary team and support staff to participate in future research to explore their views regarding workplace support in this specific context. The facilitation of the entire Appreciative Inquiry cycle might leave participants with a fuller experience of the Appreciative Inquiry process and aid management at this mental health care setting in the design and implementation of actions regarding workplace support, which could facilitate the promotion of the mental health of psychiatric nurses.

I will recommend the future implementation of the design and destiny phases, for future research, to management of this mental health care setting in order to clarify and implement methods to facilitate more effective means of providing holistic workplace support and to provide psychiatric nurses with a further opportunity to feel heard regarding the theme of workplace support. I made the following comment during one of the reflective interviews with one of the discussion leaders after one of the small core group inquiries:

"The feeling of the participants was very positive after the discovery phase discussion. It is as if uhm, they said we have this and this and this to feel positive about. After the dream phase, it was as if they, uhm, felt less positive. I would really like to go on with the process (implement the complete 4-D cycle). *I wonder what the emotions* (participants' emotions) *would be if we could implement the whole process.* (design and delivery phase). *I really feel there is a need to go further, they* (psychiatric nurses) *need to feel heard* (regarding workplace support).

I recommend the implementation of the Appreciative Inquiry approach in other areas of interest, other than workplace support, for all the employees at this mental health care setting, by an independent individual experienced in the facilitation of an Appreciative Inquiry process. Examples of proposed Appreciative Inquiry interventions might include areas like communication at work, continuous learning and leadership (Cooperrider, et al. 2008:38).

I will describe the recommendations generated during the dream phase questions of the core groups and the individual interviews to members of nursing management from this mental health care setting in a report and will communicated it to the nursing management myself. I will also provide members of nursing management from this mental health care setting with a report indicating the experiences and wishes of psychiatric nurses regarding workplace support, as generated during the discovery phases of the data collection. I will suggest that members of management from this mental health care setting consider the wishes verbalised by psychiatric nurses in order to take action on the various wishes that participants expressed to facilitate the promotion of the mental health of psychiatric nurses.

Recommendations related to the theme of supporting the body as the physical dimension of the psychiatric nurse included the wish for more flexible shifts and a wish for additional physical safety for psychiatric nurses in the mental health care environment in which they work.

Participants who worked night duty verbalised a need to work two or three nights instead of seven. I also recommend the implementation of flexible shifts by allowing nurses to partake in a self-scheduling system, where nurses are responsible for arranging their own off-duty times in collaboration with a member from middle management.

I recommend continuous education regarding crisis intervention skills and the management of an aggressive mental health care user in order to promote the physical safety of psychiatric nurses. I also recommend the evaluation of mental health care users during the assessment phase of the admission process for possible aggression in order to alert psychiatric nurses. The topic of management of an aggressive mental health care user can also be included in the in-service training programme. I also suggest the availability of additional security personnel, doing continuous rounds in the mental health care setting.

Recommendations related to the theme of supporting the mind as the cognitive and emotional dimension of the psychiatric nurse included a wish for more informal information

sharing and a wish for an independent mediator. This included members of senior nursing management who provided informal information-sharing sessions in the wards during working hours and the orientation of new and agency staff by senior nursing management members. Psychiatric nurses also verbalised a wish to interact more with the multi-disciplinary team regarding the sharing of information concerning the treatment plan of mental health care users. I propose weekly meetings between psychiatric nurses and members of the multi-disciplinary team, like occupational therapists, psychologists and psychiatrists, in order to share information and to optimise the formulation and execution of the nursing care plans for the mental health care users.

Participants working night duty also verbalised a need for informal information sharing during the night. I suggest the forming of a journal club at night in order to provide night staff with information, as well as communication between day and night staff pertaining to information sharing.

Participants in this research verbalised a need to involve the nursing students who are allocated to this mental health care setting from time to time in the information sharing. Psychiatric nursing students can be invited to join the journal clubs and the in-service training sessions.

A dream verbalised by the participants was a wish for an independent mediator. The purpose of such an independent mediator would be to consult or council psychiatric nurses regarding situations at work or in their personal life or providing psychiatric nurses with an opportunity to debrief. I suggest the appointment of an advanced psychiatric nurse practitioner, a registered nurse who is “educationally prepared as a clinical nurse specialist or a nurse practitioner at the master's or doctorate level in the speciality of psychiatric-mental health nursing” and who may conduct psychotherapy and consultation (Kneisl & Trigoboff, 2009:21-22). An advanced psychiatric nurse practitioner can also be consulted regarding the in-service training programme, research, systems and protocols of this mental health care setting and nursing care plans for the mental health care users.

Recommendations related to the theme of supporting the spirit as the relationship and conscience dimension of the psychiatric nurse included the wish for additional spiritual support to psychiatric nurses in the form of the availability of a spiritual counsellor. I suggest that a spiritual counsellor be available to the mental health care users as well as psychiatric nurses.

The theme of supporting the physical environment of the psychiatric nurse consisted of two categories, namely a wish for an improved therapeutic environment and a wish to use systems more effectively. Based on the wish verbalised by the participants, I recommend a private and quiet environment outside for psychiatric nurses to relax in during their breaks.

Participants also verbalised the wish to use the existing systems more effectively. I suggest that members from senior hospital management involve psychiatric nurses when planning procedures like the admission procedure of a mental health care user, the record-keeping procedures and the process of ordering medication from the pharmacy, in order to obtain their input.

I suggest the implementation of an Appreciative Inquiry process in order to facilitate more effective teamwork, involving nurses (psychiatric nurses, enrolled nurses and care workers), members from the multi-disciplinary team and support staff (cleaning services, maintenance, kitchen and security). Participants wished for all the various teams and services to work together more effectively. An advanced psychiatric nurse practitioner can aid in the implementation of an Appreciative Inquiry process.

The theme of support in terms of the social environment of the psychiatric nurse led to recommendations with regard to increasing the acknowledgement of the knowledge and skills of psychiatric nurses by members of the multi-disciplinary team. This recommendation can also be implemented by means of the facilitation of an Appreciative Inquiry workshop regarding relationships between the multi-disciplinary team.

The final theme of support in terms of the spiritual environment of the psychiatric nurse led to the recommendation for the incorporation of alternative therapies in the treatment programme for the mental health care users, like light therapy or colour therapy. Complementary medicines that are not yet available at this mental health care setting, which I can recommend, include yoga, biofeedback, chiropractic manipulation, massage, healing touch, colour therapies and light therapies (Kneisl & Trigoboff, 2009:873).

4.5.4 Psychiatric nursing practice

Recommendations regarding psychiatric nursing practice that emerged from this research on workplace support at a mental health care setting can be summarised by saying that psychiatric nurses ought to take responsibility for receiving and giving holistic support in the

work environment. The facilitation of the Appreciative Inquiry process was the first step in generating this awareness.

Psychiatric nurses ought to take personal responsibility for informal information sharing by continuing the journal clubs, for example. Psychiatric nurses can also take personal responsibility for the effective functioning of existing systems and the relationships with members of the multi-disciplinary team. Appreciative Inquiry can be used in this regard as discussed under recommendations earlier. Appreciative Inquiry can also be used in the daily practices of psychiatric nurses as an intervention method when providing services to the mental health care users as discussed in paragraph 4.5.1, psychiatric nursing research.

4.6 SUMMARY

In chapter 4, I described the justification for my research on workplace support, as well as describing the limitations of this research in terms of the research design and the research methods. I discussed the conclusions, based on the findings, of this research in terms of a holistic approach to workplace support under the various identified themes. Finally, I discussed the recommendations resulting from the conclusions with reference to psychiatric nursing research, psychiatric nursing education, psychiatric nursing management and psychiatric nursing practice.

I conclude my research by evaluating whether my objectives were reached. The overall purpose for performing this research was to conduct an Appreciative Inquiry in order to generate an in-depth understanding of the experiences and wishes of psychiatric nurses regarding workplace support in a private mental health care setting. I generated an in-depth understanding, reflected by my findings in chapter 3.

The objectives for the research were to explore and describe the experiences regarding workplace support of psychiatric nurses in a private mental health care setting, to explore and describe the wishes of psychiatric nurses regarding workplace support in a private mental health care setting and to propose recommendations regarding workplace support in order to facilitate the promotion of the mental health of psychiatric nurses working in a private mental health care setting with reference to psychiatric nursing research, psychiatric nursing education, psychiatric nursing management and psychiatric nursing practice. Chapter 4 consolidated my recommendations on workplace support in terms of psychiatric nursing research, psychiatric nursing education, psychiatric nursing management and

psychiatric nursing practice. The mental health of psychiatric nurses may be promoted as workplace support is provided in this setting.

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ADDENDUM A

APPROVAL LETTER FROM ETHICS COMMITTEE

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

7/06/2010

Number	:	**S54/2010**
Title	:	An appreciative inquiry of psychiatric nurses' experience of workplace support in a private mental health care setting
Investigator	:	Mrs M C I Swart, Department of Nursing Science, University of Pretoria (Supervisors: Dr E S Janse Van Rensburg/ Dr R G Visagie)
Sponsor	:	**None**
Study Degree:		**M.Cur Psychiatric Nursing**

This Student Protocol was approved by the Faculty of Health Sciences Research Ethics Committee, University of Pretoria on 7/06/2010. The approval is valid for a period of 3 years.

Prof M J Bester	BSc (Chemistry and Biochemistry); BSc (Hons)(Biochemistry); MSc(Biochemistry); PhD (Medical Biochemistry)
Prof R Delport	(female)BA et Scien, B Curationis (Hons) (Intensive care Nursing), M Sc (Physiology), PhD (Medicine), M Ed Computer Assisted Education
Prof V.O.L. Karusseit	MBChB; MFGP (SA); MMed (Chir); FCS (SA)
Prof J A Ker	MBChB; MMed(Int); MD – Vice-Dean (ex officio)
Dr M L Likibi	MBChB; Med.Adviser (Gauteng Dept.of Health)
Dr MP Mathebula	Deputy CEO: Steve Biko Academic Hospital
Prof T S Marcus	(Female) BSc (LSE), PhD (University of Lodz, Poland)
Prof A Nienaber	(Female) BA (Hons) (Wits); LLB (Pretoria); LLM (Pretoria); LLD (Pretoria); PhD; Diploma in Datametrics (UNISA)
Prof L M Ntlhe	MBChB(Natal); FCS(SA)
Mrs M C Nzeku	(Female) BSc(NUL); MSc Biochem(UCL,UK)
Snr Sr J. Phatoli	(Female) BCur (Et.Al); BTech Oncology
Dr R Reynders	MBChB (Pret), FCPaed (CMSA) MRCPCH (Lon) Cert Med. Onc (CMSA)
Dr T Rossouw	(Female) MBChB.(cum laude); M.Phil (Applied Ethics) (cum laude), MPH (Biostatistics and Epidemiology (cum laude), D.Phil
Mr Y Sikweyiya	MPH (Umea University Umea, Sweden); Master Level Fellowship (Research Ethics) (Pretoria and UKZN); Post Grad. Diploma in Health Promotion (Unitra); BSc in Health Promotion (Unitra)
Dr L Schoeman	(Female) BPharm (NWU); BAHons (Psychology)(UP); PhD (UKZN); International Diploma in Research Ethics (UCT)
Dr R Sommers	**Vice-Chair** (Female) - MBChB; MMed (Int); MPharMed.
Prof T J P Swart	BChD, MSc (Odont), MChD (Oral Path), PGCHE
Prof G van Biljon	(female)FCP (Paed)SA
Prof C W van Staden	**Chairperson** - MBChB; MMed (Psych); MD; FCPsych; FTCL; UPLM; Dept of Psychiatry

Student Ethics Sub-Committee

Prof R S K Apatu	MBChB (Legon,UG); PhD (Cantab); PGDip International Research Ethics (UCT)
Dr A M Bergh	(female) BA (RAU); BA (Hons) (Linguistics) (Stell); BA (Hons) (German) (UNISA); BEd (Pretoria); PhD (Pretoria); SED (Stell)
Mrs N Briers	(female) BSc (Stell); BSc Hons (Pretoria); MSc (Pretoria); DHETP (Pretoria)
Dr S I Cronje	BA (Pretoria); BD (Pretoria); DD (Pretoria)
Prof M M Ehlers	(female) BSc (Agric) Microbiology (Pret); BSc (Agric) Hons Microbiology (Pret); MSc (Agric) Microbiology (Pret); PhD Microbiology (Pret); Post Doctoral Fellow (Pret)
Prof D Millard	(female) B.Iur (Pretoria); LLB (Pretoria); LLM (Pretoria); AIPSA Diploma in Insolvency Law (Pretoria); LLD (UJ)
Dr S A S Olorunju	BSc (Hons). Stats (Ahmadu Bello University –Nigeria); MSc (Applied Statistics (UKC United Kingdom); PhD (Ahmadu Bello University – Nigeria)
Dr L Schoeman	CHAIRPERSON: (female) BPharm (North West); BAHons (Psychology)(Pretoria); PhD (KwaZulu-Natal); International Diploma in Research Ethics (UCT)
Dr R Sommers	**Vice-Chair** (Female) MBChB; M.Med (Int); MPhar.Med

DR L SCHOEMAN; BPharm, BA Hons (Psy), PhD; Dip. International Research Ethics
CHAIRPERSON of the Faculty of Health Sciences Student Research Ethics Committee, University of Pretoria

DR R SOMMERS; MBChB; M.Med (Int); MPhar.Med.
VICE-CHAIR of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

☎ 012 354 1677 🖷 0866516047 deepeka.behari@up.ac.za http://www.healthethics-up.co.za
✉ P O Box 667, Pretoria, 0001 31 Bophelo Road, HW Snyman South Building, Level 2, Room 2.33, Gezina, Pretoria

ADDENDUM B

APPROVAL LETTER FROM MENTAL HEALTH CARE SETTING

Mrs MCI Swart

012 332 3312

082 795 1005

mciswart@vodamail.co.za

MARCH 2010

[redacted]

REQUEST TO CONDUCT RESEARCH AT THIS PRIVATE MENTAL HEALTH CARE SETTING

I am currently enrolled for M Cur Psychiatry at the University of Pretoria. I would like to request written permission to conduct research at this private mental health care setting, **AN APPRECIATIVE INQUIRY OF PSYCHIATRIC NURSES' EXPERIENCE OF WORKPLACE SUPPORT IN A PRIVATE MENTAL HEALTH CARE SETTING.**

I plan to conduct the data collection phase of my research in two independent seminars on two separate dates. I will adhere to strict ethical measures during my research. I will make a report of the findings available to this mental health care setting.

Please find attached a copy of my proposal, explaining the research methods and ethical considerations fully, an information sheet and consent form and an interview schedule for your attention.

My supervisors at UP are Mrs E Janse van Rensburg and Mrs R Visagie. Please feel free to contact me or my supervisors if there are any questions regarding this research.

I would like to thank everybody in advance for your participation in this research.

You hereby give consent to

- collaborate in the proposed research
- allow your employees to participate in the proposed research
- make your conference facilities available for the proposed research

Signed at PRETORIA this 13 day of APRIL 2010

Mrs MCI Swart

Researcher

[redacted]

Medical Superintendent

[redacted]

Managing Director

[redacted]

Nursing service Manager

ADDENDUM C

PARTICIPANT INFORMATION LEAFLET AND INFORMED CONSENT FORM

(Adapted from Ethics Committee form PIC. 3)

TITLE OF STUDY: An Appreciative Inquiry of psychiatric nurses' experience of workplace support in a private mental health care setting.

Dear Participant

1. INTRODUCTION

I am currently doing my M Cur degree at the University of Pretoria. I would like to invite you to participate in a research project on the subject of workplace support at the mental health care setting where you are currently employed. Before you agree to take part, you should fully understand what is involved. If you have any questions that this leaflet does not fully explain, please do not hesitate to ask the investigator, Mariëtte Swart.

2. THE NATURE AND PURPOSE OF THIS STUDY

The aim of this study is to conduct an Appreciative Inquiry in order to generate an in-depth understanding of psychiatric nurses' experiences of workplace support and to propose recommendations regarding the facilitation of future workplace support in a private mental health care setting. You as a psychiatric nurse are a very important source of information on workplace support.

3. EXPLANATION OF PROCEDURES TO BE FOLLOWED

The research team will consist of four individuals namely me, the researcher, a co-facilitator, and my two supervisors, who will be taking field notes during the data collection phase. This study involves a single group session, lasting for four hours, with a tea break of thirty minutes. The researcher will introduce the steps of the data collection to participants, including a brief background of Appreciative Inquiry and the interview techniques that will be used during data collection. The researcher will then divide participants into pairs, and give each participant an interview schedule. Participants will be interviewing each other one-on-one for fifteen minutes each, according to the interview schedule. Participants will write down all the answers acquired during their interviews. Each pair of participants will be given the opportunity to give feedback from their interviews. The co-facilitator, in conjunction with the group,

will obtain consensus and identify main emerging themes during feedback, and write this on a white board, as a positive core map, for all group members to see. It is important to note that I will be making use of a digital voice recorder during our group discussions.

4. RISK AND DISCOMFORT INVOLVED

The risks in participating in this study involve that some of the questions I am going to ask you may make you feel uncomfortable, but you need not contribute information if you do not want to. The researcher will be able to evaluate the impact of the data collection phase on participants during the feedback phase from participants. Possible negative effects might include the sharing of past negative experiences and the associated emotions from those experiences. The researcher will be available after the data collection phase for support or referrals if necessary. You are also expected to travel to the venue once and to participate in your own time, approximately four hours, without compensation.

5. POSSIBLE BENEFITS OF THIS STUDY

You will benefit directly by participating in this study because of the Appreciative Inquiry method used, which can be supportive in nature and can enhance collaboration of psychiatric nurse practitioners and management. The results from the study can enable better workplace support in future by recommendations made to organisational policy.

6. WHAT ARE YOUR RIGHTS AS A PARTICIPANT?

Your participation in this study is entirely voluntary. You can refuse to participate or stop at any time during the study, without giving any reason. Your withdrawal will not affect you in any way.

7. HAS THE STUDY RECEIVED ETHICAL APPROVAL?

This study has received written approval from the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria. A copy of the approval letter is available if you wish to have one.

8. INFORMATION AND CONTACT PERSON

The contact person for the study is Mariëtte Swart. Please feel free to contact me if you have any questions or comments regarding this research.

mciswart@vodamail.co.za
(S) 082 795 1005
(H) 012 332 3312

You can alternatively contact one of my supervisors at UP.

Dr E S Janse van Rensburg	Dr R G Visagie
082 322 6905	082 436 6630

9. COMPENSATION

Your participation is voluntary. No compensation will be given to you in any way, either by me or by the private mental health care setting where you are employed, for your participation, time or transport.

10. CONFIDENTIALITY

All information that you give will be kept strictly confidential. Once I have analysed the information no one will be able to identify you. Research reports will not include any information that may identify you or your clinic.

CONSENT TO PARTICIPATE IN THIS STUDY

I confirm that the person asking my consent to take part in this research has informed me about the nature, process, risks, discomforts and benefits of the study. I have also received, read and understood the above written information (Information leaflet and informed consent) regarding the study. I am aware that the results of the study, including personal details, will be anonymously processed into research reports. I am participating willingly. I have had time to contact the researcher and to ask questions and have no objection to participate in the study. I understand that there is no penalty should I wish to discontinue with the study and my withdrawal will not affect me in any way.

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

Participant's name…… (Please print)

Participant's signature…… Date…..……

Researcher's name……. (Please print)

Signature…….…….. Date…….……

Witness's name…….……. (Please print)

Signature…….…….…… Date……..……..…..

ADDENDUM D

DEMOGRAPHIC INFORMATION

Please be so kind as to provide me with the following information about yourself. It is important to note that I would not use any of this information to identify you during data analysis or in the final report.

SURNAME:

_____

NAME:

_____

AGE: _____

GENDER: _____

RACE: _____

MARITAL STATUS:_____

DEPENDANTS: _____

AVERAGE HOURS SPENT AT WORK PER MONTH: _____

WHEN DO YOU MOSTLY WORK (DAY/NIGHT): _____

TIME EMPLOYED BY THIS MENTAL HEALTH CARE SETTING (MONTHS):

_____

OTHER PSYCHIATRIC NURSING EXPERIENCE (MONTHS):

_____

ADDENDUM E

INTERVIEW SCHEDULE

When our organisation is functioning at its best, it offers diverse methods of workplace support for us.

DISCOVERY PHASE

1. What actions from colleagues or supervisors makes you feel most supported at work?

DREAM PHASE

Dream into the future and imagine this organisation giving you the best possible support at work.

2. Please describe this dream.

---

3. Please describe your wishes in order to realise your dream.

ADDENDUM F

TIME SCHEDULE FOR SMALL CORE GROUP INQUIRIES

08:00 - 09:00	Interview with discussion leader to clarify expectations
09:00 - 09:15	Relationship phase: Welcome, introduction/AI/structure - Mrs Swart
09:15 - 09:30	Discovery phase interviews 1 - one-on-one participant interviews in pairs
09:30 - 09:45	Discovery phase interviews 2 - one-on-one participant interviews in pairs
09:45 - 10:45	Feedback (10 min per person)/ Drawing of positive core map, identifying of emerging themes and summary. Nominal group technique - Discussion leader
10:45 - 11:15	Tea
11:15 - 11:30	Dream phase interviews 1 - one-on-one participant interviews in pairs
11:30 - 11:45	Dream phase interviews 2 - one-on-one participant interviews in pairs
11:45 - 12:45	Feedback (10 min per person)/Drawing of positive core map, identifying of emerging themes and summary. Nominal group technique - Discussion leader
12:45 - 13:00	Termination phase: questions/acknowledgements - Mrs Swart
13:00 - 13:30	Mrs Swart is available for support, to make a reference or an appointment
13:30 - 14:00	Reflective interview - Discussion leader

ADDENDUM G

CONFIDENTIALITY AGREEMENT WITH CO-FACILITATOR

Mrs MCI Swart
1255 Breyer Avenue
Waverley
0186
012 332 3312 / 082 795 1005
mciswart@vodamail.co.za

[redacted]

23 June 2010

CONFIDENTIALITY AGREEMENT

I am acting as co-facilitator in the core group inquiry that is being held as part of the data collection for the study **AN APPRECIATIVE INQUIRY OF PSYCHIATRIC NURSES' EXPERIENCE OF WORKPLACE SUPPORT IN A PRIVATE MENTAL HEALTH CARE SETTING.**

I agree to handle all information obtained in this core group inquiry as confidential. I will protect study participants by never revealing any of the information obtained on 23 June 2010. I will not disclose or discuss participant's identity or information obtained with anybody, except the researcher, Mrs MCI Swart, and her supervisors, Dr ES Janse van Rensburg and Dr RG Visagie.

Signed on 23 June 2010 at Pretoria.

[redacted]
Co-facilitator

Mrs MCI Swart
Researcher

ADDENDUM H

CONFIDENTIALITY AGREEMENT WITH CO-CODER

Mrs MCI Swart
1255 Breyer Avenue
Waverley
0186
012 332 3312 / 082 795 1005
mciswart@vodamail.co.za

[redacted]

22 October 2010

CONFIDENTIALITY AGREEMENT

I am acting as co-coder and to verify identified themes of the data collected for the study **AN APPRECIATIVE INQUIRY OF PSYCHIATRIC NURSES' EXPERIENCE OF WORKPLACE SUPPORT IN A PRIVATE MENTAL HEALTH CARE SETTING.**

I agree to handle all information relating to this study as confidential. I will protect study participants by never revealing any of the information obtained during coding of the data. I will not disclose or discuss participant's identity or information obtained with anybody, except the researcher, Mrs MCI Swart, and her supervisors, Dr ES Janse van Rensburg and Dr RG Visagie.

Signed on 22 October 2010 at Pretoria.

[redacted]

Co-coder

Mrs MCI Swart

Researcher

ADDENDUM I

WORKING PROTOCOL FOR CO-CODER

(According to Tesch, R. 1990. Qualitative Research analysis types & software tools.)

- Read through all the data while reflecting on and noting clusters of themes, to get an overview of the content.

- Select one text and note the topic, not the content. (Repeat with all the other texts). Highlight the key phrases and note personal thoughts.

- Compile a list of all the topics.

- Formulate a list of themes by clustering similar topics together. Note comparisons and contrasts between themes and compile central themes and unique themes.

- Select a describing word or phrase or an explanatory sentence for each theme and note the interrelationship between themes.

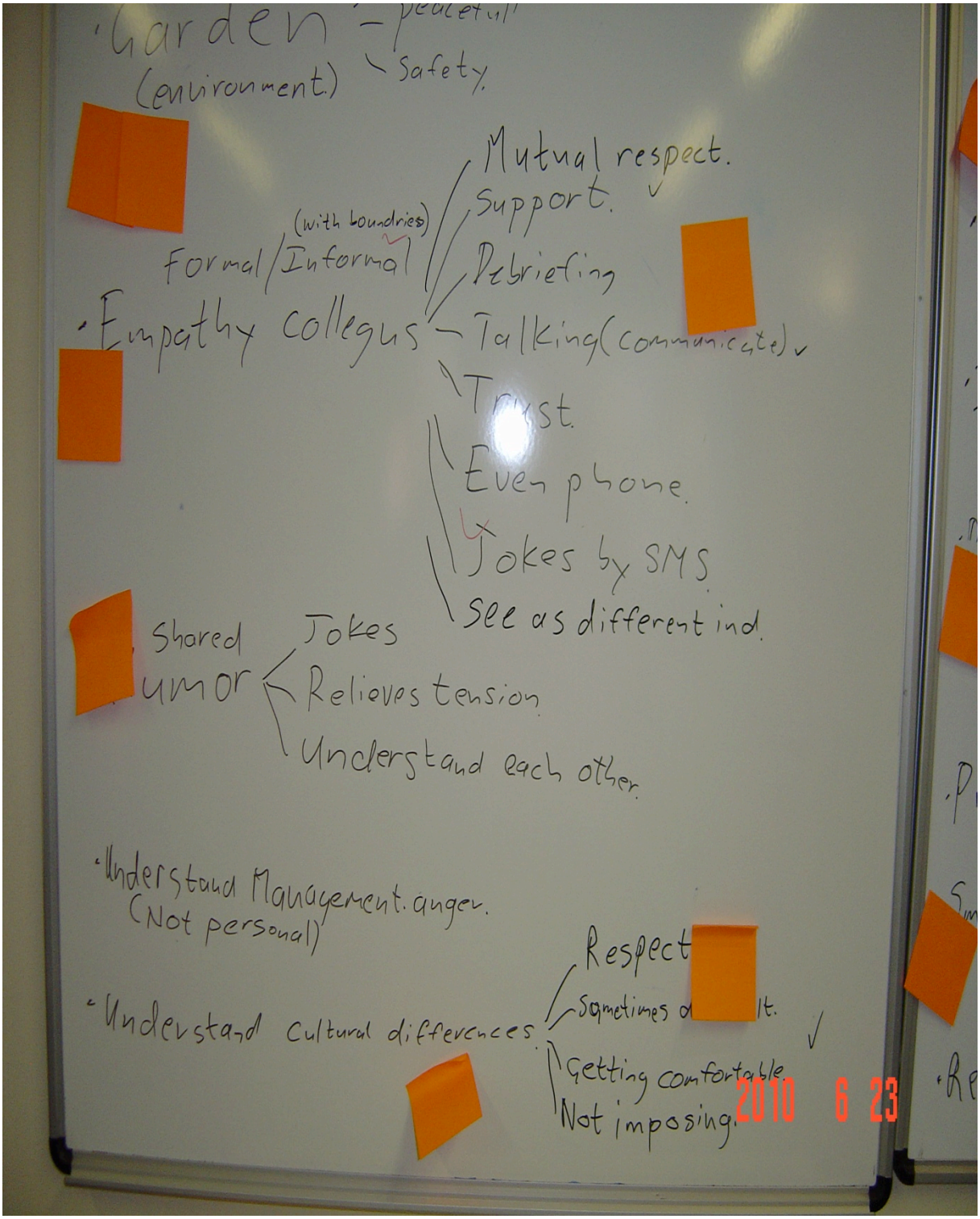
- Organise these themes and add additional themes.

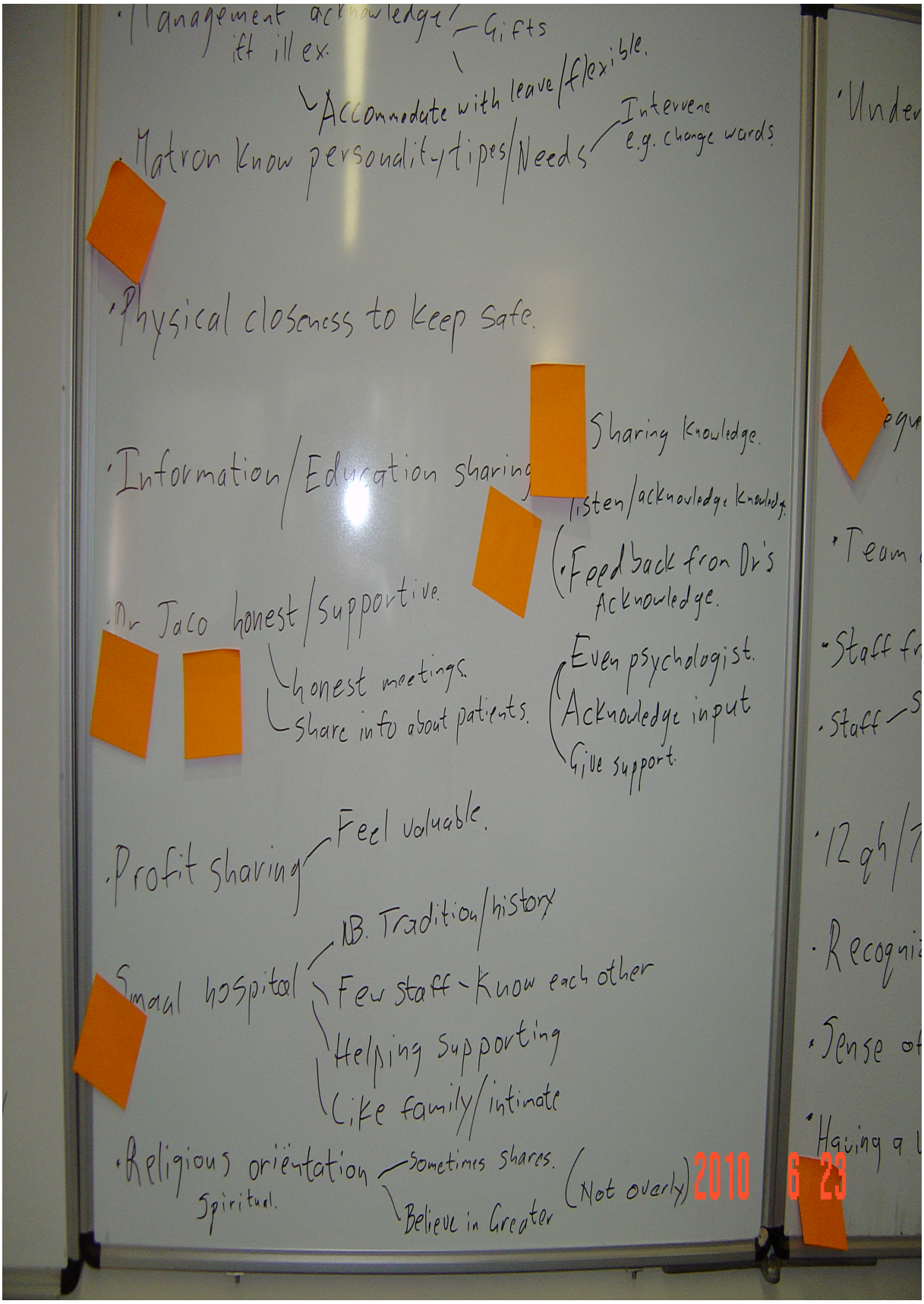
- Make a final decision regarding the naming of the themes.

- Reread through the data and pay attention to the content, recoding if necessary, to check whether new themes or categories emerge.

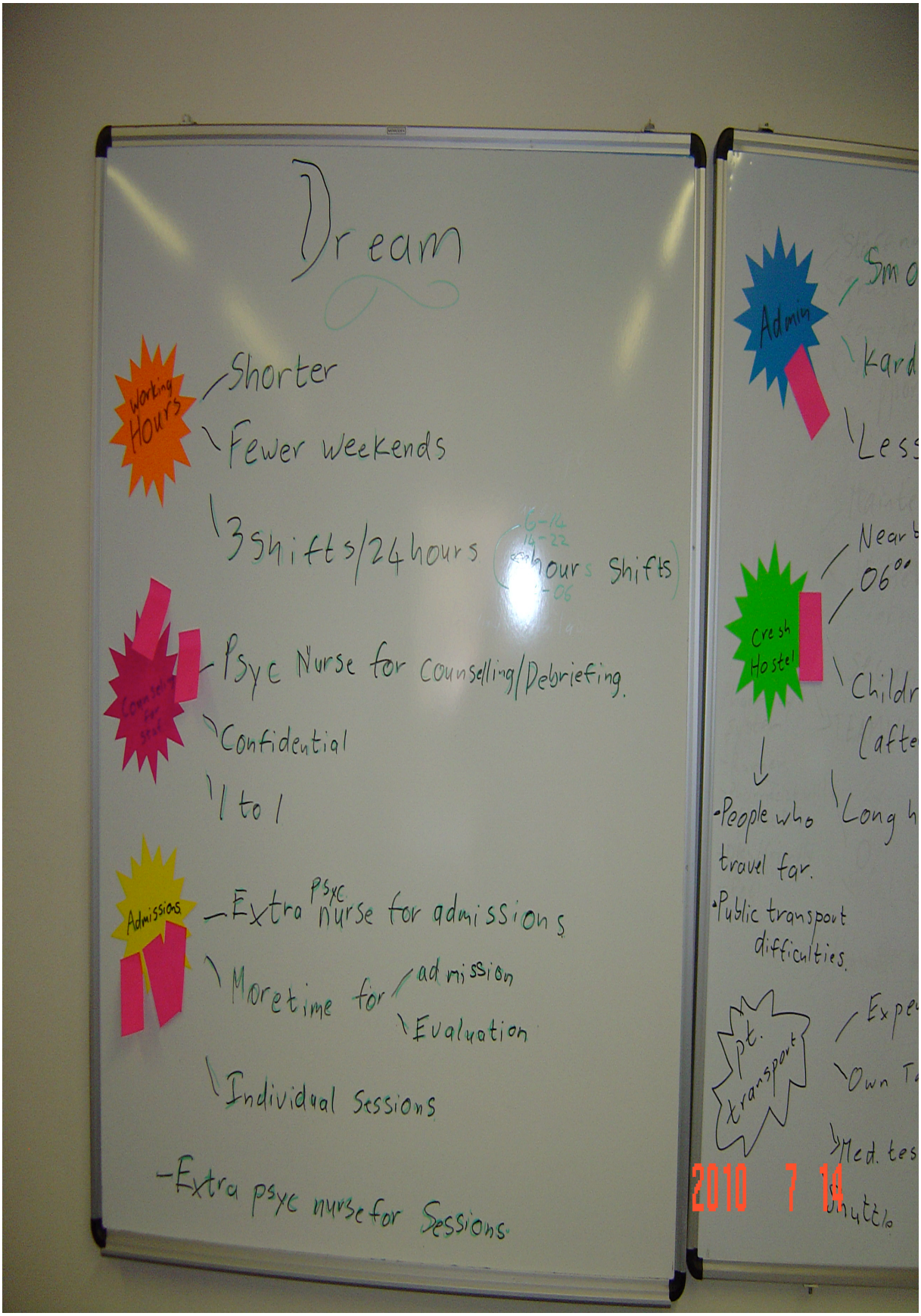
ADDENDUM J

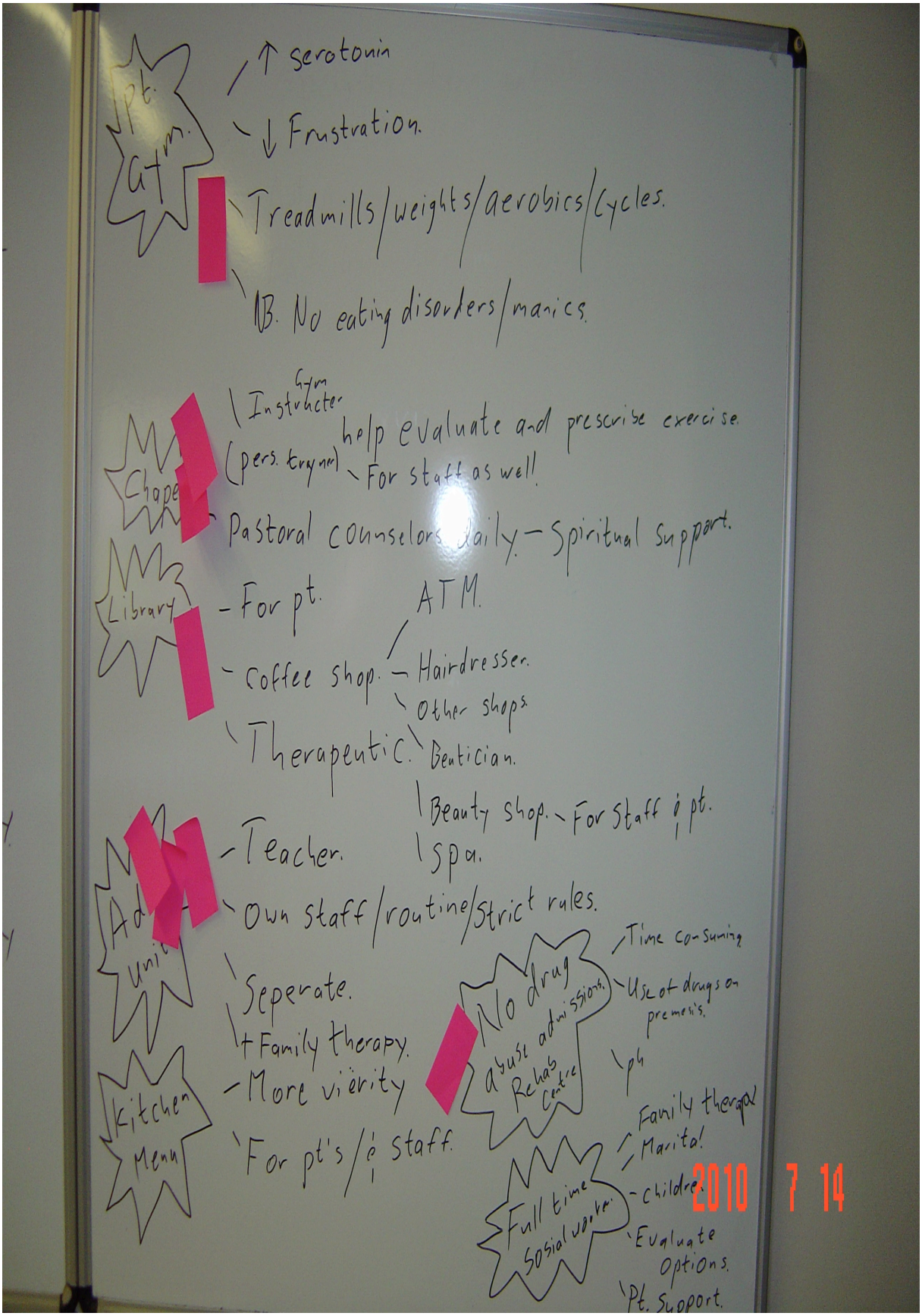
PICTURES OF POSITIVE CORE MAPS

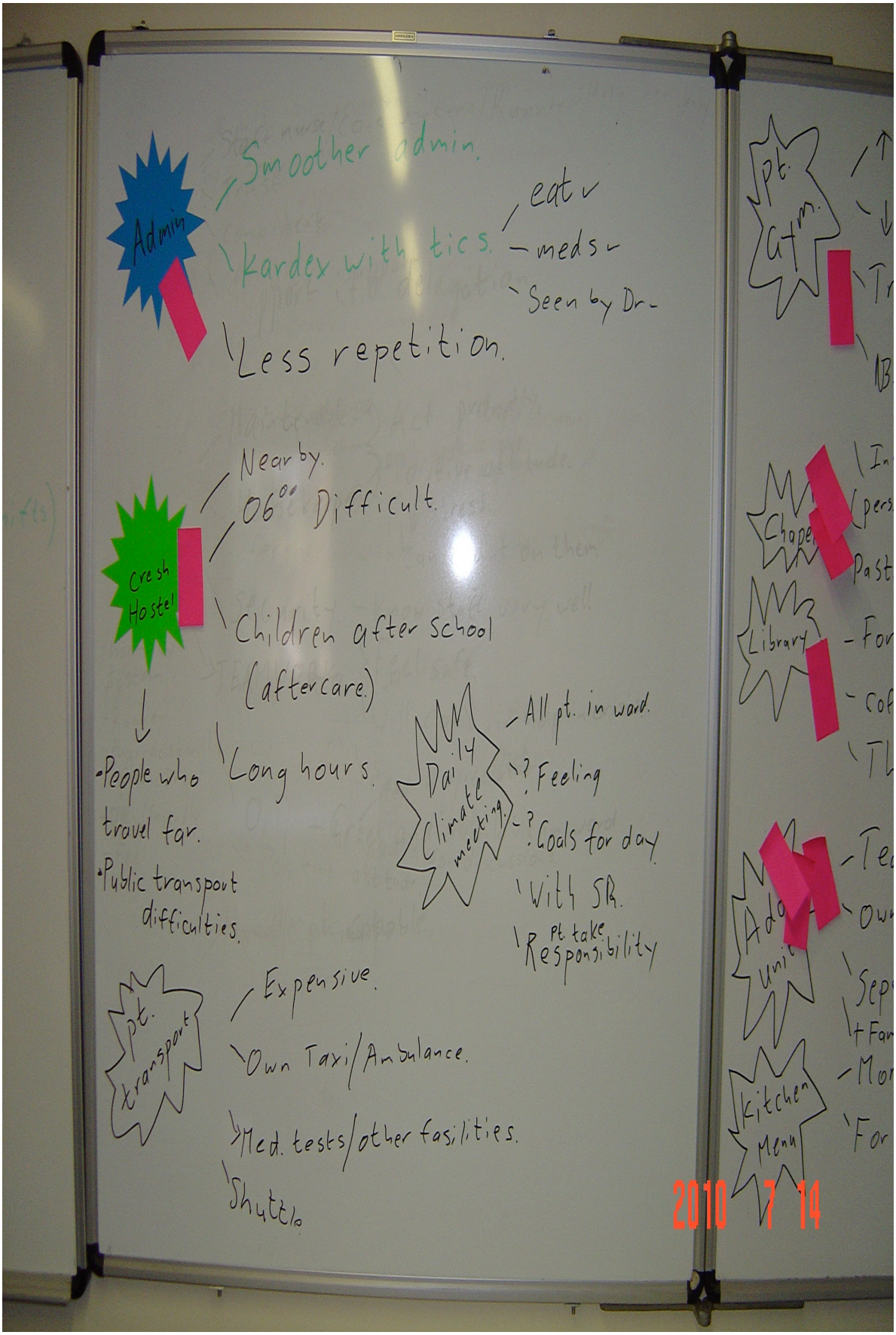

Garden - peaceful
(environment) Safety
Mutual respect.
Support.
Debriefing
Formal/Informal (with boundries)
Empathy collegus
Talking (communicate)
Trust.
Even phone.
Jokes by SMS
See as different ind.
Shared umor
Jokes
Relieves tension
Understand each other
Understand Management. anger.
(Not personal)
Understand Cultural differences
Respect
Sometimes
Getting comfortable
Not imposing.
2010 6 23


Management acknowledge / Gifts
if ill ex.
Accommodate with leave / flexible.
Matron know personality types / Needs
Intervene
e.g. change words
Physical closeness to keep safe.
Information / Education sharing
Sharing knowledge.
listen / acknowledge knowledge.
Feedback from Dr's
Acknowledge.
Dr Jaco honest / supportive.
honest meetings.
Share info about patients.
Even psychologist.
Acknowledge input
Give support.
Profit sharing
Feel valuable.
Small hospital
NB. Tradition / history
Few staff - Know each other
Helping Supporting
Like family / intimate
Religious orientation
Spiritual.
Sometimes shares.
Believe in Greater
(Not overly)
2010 6 23


SR. Support in wards
Management acknowledge
Cards
Gifts
Accommodate with leave/flexible.
Matron know personality/Types/Needs
Intervene e.g. change wards
Physical closeness to keep safe.
Information/Education sharing
Sharing knowledge.
Listen/acknowledge, knowledg
Feedback from Dr's
Acknowledge.
Dr Jaco honest/supportive.
Honest meetings
Share info about patients.
Even psychologist.
Acknowledge input
Give support
Profit sharing
Feel valuable.
Small hospital
NB. Tradition/history
Few staff - Know each other
Helping supporting
Like family/intimate
Religious orientation
Sometimes shares.
Believe in Greater
(Not overly)
Mutual respect.
Support.
Debriefing
Talking(communicate)
Trust
Even phone
Jokes by SMS
See as different ind.
tension
Respect
Getting comfortable.
Not imposing.
Underlying sense of Prof. work
Respect different
Respect different skills.
Team effort - Work together
Staff from different wards work
Staff - Sense of self awareness.
12 gh/7 nights feel too long.
Recognize challenge and spirit of
Sense of self support
voice needs.
Self aware
Having a voice - can verbalise needs.
2010 6 23


Dream
Working Hours
Shorter
Fewer weekends
3 shifts/24 hours
Psyc Nurse for counselling/Debriefing.
Confidential
1 to 1
Admissions
Extra psyc nurse for admissions
More time for admission
Evaluation
Individual sessions
Extra psyc nurse for Sessions.
Admin
Cresh Hostel
People who travel far.
Public transport difficulties.
pt. transport
2010 7 14


Pt. Gym.
↑ Serotonin
↓ Frustration.
Treadmills/weights/aerobics/cycles.
B. No eating disorders/manics.
Chapel
Gym Instructor (pers. trng nm) help evaluate and prescribe exercise.
For staff as well
Pastoral counselors daily - Spiritual support.
Library
For pt.
ATM.
Coffee shop.
Hairdresser.
Other shops.
Therapeutic.
Beautician.
Beauty shop. - For staff & pt.
Spa.
Ad Unit
Teacher.
Own staff/routine/strict rules.
Seperate.
+ Family therapy.
More vierity
For pt's & staff.
Kitchen Menu
No drug abuse admissions. Rehab Centre
Time consuming
Use of drugs on premesis.
pt
Full time Sosial worker
Family therapy
Marital
Children
Evaluate Options.
Pt. Support.
2010 7 14


Admin
Smoother admin.
Kardex with tics.
eat ✓
meds ✓
Seen by Dr.
Less repetition.
Cresh Hostel
Near by.
06h00 Difficult.
Children after school (aftercare)
Long hours.
People who travel far.
Public transport difficulties.
Daily Climate meeting.
All pt. in ward.
? Feeling
? Goals for day
With SR.
Pt. take Responsibility
pt. transport
Expensive.
Own Taxi/Ambulance.
Med. tests/other fasilities.
Shuttle
pt. Gym.
Chapel
Library
Kitchen Menu
2010 7 14

ADDENDUM K

EXAMPLE OF A COMPLETED NAÏVE SKETCH

Please write a story and tell me about a peak experience at work, when you felt most supported.

Daar is 'n paar dinge in die kliniek wat ek as verpleegkundige as baie ondersteunend ervaar.

Die feit dat ons twee verpleegdiensbestuurders elke dag rondtes doen in die sale, en elke oggend en aand saam met hoofverpleegkundiges rondtes doen met oorgee.

Die hoofverpleegkundige aan diens vir die dag doen twee maal 'n dag rondtes en is die hele dag beskikbaar as daar 'n krisis in die saal is.

Ons besturende direkteur en besturende psigiater doen weekliks rondtes in die saal om te hoor van enige probleme en tree vinnig op as daar enige versoeke of probleme is.

Daar is maandeliks 'n vergadering van 'n uur wat 'n oop vergadering is en enige iets kan bespreek word.

Die feit dat ons twee verpleegdiensbestuurders die hele oggend beskikbaar is, en ek hulle enige tyd kan bel vir ondersteuning, selfs om medikasie uit te deel, as daar 'n krisis in die saal is, of 'n tekort aan personeel.

ADDENDUM L

EXAMPLE OF A TRANSCRIBED CORE GROUP DISCUSSION

TRANSCRIPTION: DREAM PHASE (SECOND INQUIRY)

Discussion leader: So, in your small group you have discussed now what your dream for the future was, in terms of this organisation, relating to support in your workplace. Can you please describe your dream for us? You can just close your eyes and imagine this organisation giving you the best possible support, in terms of what the best possible situation would be, and then you need to describe your dream. If you had a magic wand, and you could transform this setting magically. Would you like to describe your dream if there were no boundaries?

Participant 6: Does it need to be like a new thing?

Discussion leader: Anything. What will make it better for you?

Participant 5: You know that it is not always practical possible.

Discussion leader: Yes.

Participant 7: But I think one thing that is always in any nursing situation, is your working hours. Because it really does have an influence on your whole social life. So, shortly the ideal would be no working on the weekends.

Discussion leader: The working hours, how will it be? If it was an ideal?

Participant 7: It would be more like office hours so you have three shifts, instead of two shifts for 24 hours per day.

Discussion leader: In terms of times, have you thought about that? How that will work, or the times?

Participant 6: Eight hours. Like six to two, two to 10 and 10 to six. We did not think about the practical part, but it will be eight-hour shifts.

Participant 7: Yes, eight hour shifts.

Participant 7: Because in reality, to find somebody to come in at 10 at night, is bad, but just to have it divided, instead of the 12 hour shifts.

Discussion leader: Yes.

Participant 6: Is it all right, if I say this piece in Afrikaans? (Afrikaans). It is a dream, something that I would like to do. It is just to have a psychiatric nurse in the clinic that does counselling to staff, that is available daily. Yes. Not a psychologist, but a psychiatric nurse. That knows what is happening at work. That gives debriefing for the personnel.

Discussion leader: So counselling, a psychiatric nurse that does counselling, for the nursing staff in a confidential milieu. And that is available, that you can make appointments with her.

Participant 5: And we would also like an extra psychiatric nurse, in the ward to do the admissions, or to handle a crisis. Because at this moment we feel like, we can't do everything. We do the medication, the admissions, the card decks must be written about the patients. If there is a crisis, we must give them medicine, we must sort out the crisis. When there is a patient that must get stat medication. Sometimes it feels like you are overwhelmed in the ward, because you have so much is that you must do. So if you've got a psychiatric sister, that does the admission, they can spend more or less an hour with the patient. Because now you spend 10 minutes with a patient, the luggage is already in their room and the patient is waiting to be admitted. Just to give uhm, more time to the patient to listen to the patient, and to evaluate the patient properly just to see what is then needs and the problem of the patient. Because at the moment we make time during the day to do that, which is not always possible.

Participant 6: And for individual sessions.

Participant 5: Yes.

Discussion leader: In terms of, just to, explored about the context. How many, uhm, psychiatric nurses are there per patient? What is your set-up in a ward?

Participant 5: Okay, at the moment, there is, uhm, most sisters here that's got psychiatry, but there are some of them that only have general. Uhm, so we have a nursing sister, a staff nurse and a care worker in a ward. Then you have got 26 patients. There is uhm, three wards that's got smaller with 12 patients, 17 and 18

patients. But you've got the big ward with 26 patients, so it can be quite busy, especially in the big ward. So just have an extra sister, to do the, admission, so you can do the, so you can continue with the medication. The medication takes a lot of time during the day. And we've also said the admin paper, we've got a lot of admin. Like make a system, we can only kick off that the patient had he's medication, his meals, and we have extra space where we can write the emotional stuff. How is the patient emotionally, was he manic? Because in your cardex writing, your write things three times during the day. It also takes a lot of time to write the cardex.

Participant 6: Yes, and it's always the same over and over.

Discussion leader: So the cardex, do you have specific recipe. Does everybody write the cardex in the same manner? How do you go about?

Participant 5: Everybody writes the cardex in a different way, but most of the time it is the same over and over and over. The only thing that that differs is the patient was anxious, or crying, that is the only difference. And if there was a crisis with the patient, otherwise it is the same.

Participant 6: We have write, or that is how I was learnt, the patient had their medication, you have two write that they eat, that they did not eat, three times a day. That they have seen the doctor, the good doctor changed the prescription or not. That is the only thing you had to write. All the other things you can put together, but there is no time. That is what worries me, if you write for 26 patients, you have to write all that stuff. There is no time to write about the emotional stuff of the patients, how is the patient emotionally. Okay, and there is rounds. There are two rounds during the day. You have to write where the patient was, is he okay. (Afrikaans) I think it gets sloppy actually.

Discussion leader: Does everybody write the cardex, or is it the nurse?

Participant 6: One gets appointed. (Afrikaans) It is either the nurse, you or the staff nurse. Mostly the staff nurse.

Discussion leader: Okay.

Participant 5: And we also said a crèche for the kids.

Everybody: Yes.

Participant 5: The personnel have got children, and now, is the start working at six in the morning and where do you get a crèche that is open? And especially the children that comes from school. Maybe have and facility for the children to come to the, uhm, after care. Yes, it will make it easier for the nursing personnel, because now you do not have to worry, are they home safe safely, do they do their homework. Now you know. You know that your children are safe. You do not need to worry about the children, did they do their homework, and you can concentrate on your work, on the ward.

Participant 6: It does not need to be on the premises, but nearby.

Participant 5: Yes, especially with the long hours.

Participant 6: That is very important.

Participant 5: And, uhm, we have also said a hostel for the personnel that come from far. Because most of the people comes from (name) all those small places. To have a hostel for them, especially when that public transport is striking, when there is a problem, they do not have a problem they do not need to stress about how they are going to get to work, how are they going to get home tonight. When they have worked, that there is a hostel facility.

Participant 6: Yes, because some of them must get up at four o'clock to get a taxi.

Participant 7: Long travelling time.

Participant 5: Yes. Another thing that we said is, transport for the patients when they most go for, uhm MRI scans, to see a doctor, to see another specialist, because now we must arrange transport, and the patients says they do not have enough money. Sometimes they charge you over to 200 Rands just to get to Pretoria East and to come back. If they can have their system so that we can transport the patients our self, so the tariff is being worked in the hospital bill.

Participant 6: Like our own taxi.

Participant 5: Now, the patient does not have any money, now, the nursing personnel must make a plan, because this patient must go for the brain scan now. You can't always get hold of the family or the friends to take the patient.

Participant 6: Some of them stay far.

Participant 5: Just to have a transport system intern, so that patients can be taken to the facilities, and brought back. So that you do not have that strain to arrange transport for the patient.

Discussion leader: In terms off at the facility or the clinic, you would like a crèche or a pre-primary school nearby for their children, or aftercare, that is open at six o'clock. And also, a hostel for the people who comes from far, that may have transport problems where they can stay, and maybe a shuttle to help with the patients to get to the hospital, or tests.

Participant 7: Yes, we were also talking about like a gym for the patients. Because if they can, uhm, have a work out there, their frustration gets less, and it will make our world work easier.

Everybody: Laughter.

Participant 6: And also the serotonin levels, it will help them to feel better. If they feel better, we feel better.

Discussion leader: In terms of the gym, do you have a specific in your dream, how does this gym look like?
Participant 7: Definitely, not a swimming pool, it is too dangerous.

Everybody: Laughter.

Participant 7: Yes, like something like treadmills, uhm, yes, and little bit of weights.

Participant 6: There can be a place for our aerobics, and bicycles to do some cycling.

Participant 5: And stick rules to keep the eating disorders away.

Everybody: Laughter.

Participant 6: And the manic patients.

Everybody: Laughter.
Participant 7: And maybe something like a bio-kinetics, a dietician's that is there at the gym, that can evaluate the patients, exercises like Pilatus, the balls, that they can do, because a lot of the patients have got muscle pains, stress pains.

Discussion leader: Would it be a physio, or like somebody who can help and train them?

Participant 6: Yes, somebody who can help and train them, a physio is extra.

Participant 7: Yes somebody who can help and train them, like a bio technician.

Discussion leader: A gym instructor.

Participant 6: Yes, (Afrikaans) we do not have time to do that.
Everybody: Laughter.

Participant 7: Like a person, a personal trainer.

Participant 6: A personal trainer yes.

Participant 5: And we also said a library, because some of the patients asked if there is a place where they can get some books read. Because, sometimes they do not really go to the groups and art classes, and they just want to sit and read. So to have a nice corner with a coffee shop, where they can just sit and relax, read a book, like exclusive books, like a coffee corner. And the personnel can use that as well.

Discussion leader: So that can be a dream for the therapeutic environment.

Participant 5: Yes.

Discussion leader: Like a library or a quiet place where you can have some coffee, read.

Participant 6: And we said like a little coffee shop, a little town with a coffee shop, where

you can actually go and buy something, and, uhm, the visitors can also use that, and an ATM.

Participant 7: Yes, we can include all these things, a hairdresser.

Participant 6: Yes, (Afrikaans) a beautician.

Participant 5: Yes, some of the patients wants their hair done, and their nails, and maybe go for a massage.

Participant 6: Yes, especially a manicure.

Participant 5: Yes, if you physically appear better, you will feel better.

Participant 6: (Afrikaans) yes and the staff can go for a treatment, with the beautician.

Participant 7: Or with the gym instructor.

Participant 6: That would be torture.

Everybody: Laughter.

Participant 5: Yes, and we also said we wanted a, uhm, adolescent ward. We do not want them with the adults in the hospital, we want them to have their own psychiatrist, their own registered nurses, occupational therapists may be to have a teacher that come that can go on with the uhm.

Participant 6: Schoolwork.

Participant 5: Schoolwork. Because sometimes they are here for two to three weeks, and they loose work, because they are not at school. It would be nice to have someone just to continue with the schoolwork.

Participant 6: Their own little complex, where they cannot mix.

Participant 5: Yes, with stick rules.

Participant 6: Yes.

Participant 7: Like in the old (hospital name), they had the maternity with the young girls.

Everybody: Yes.

Participant 6: A menu. We would like a menu to choose.

Participant 5: Yes, for the patients and for us.

Participant 6: Like more variety. At the lunchtime.

Participant 5: That there is two or three options.
Discussion leader: Is that for the patients or for you?

Participant 5: Both.

Participant 5: Yes, because sometimes the menu.

Participant 6: Yes sometimes there is a lot of complaints about the food. It makes u stressed up, because you can do nothing about the food, working in the wards. There are a lot of complaints.
Participant 5: Yes, and we also said not to admit patients with drug abuse. We don't have the facilities for them. You can't keep an eye on them for 24 hours. To see that they don't get drugs in. It takes a lot of time from you, because now you have to watch the patient like a hawk. To see that he is not using drugs. So, now there is a patient who really needs your help, or who is depressed. We must always be hands on with the patient with the drug abuse. When they start to withdraw. It just feel it is really unfair to the other patients that have really got a need, they must go to the rehab centre.

Participant 7: And to have a full-time social worker on the premises. Also for the patients and for the staff.

Participant 6: Yes, there is a lot of social problems.

Discussion leader: Can you give us an example of what kind of problems you will have to

refer to the social worker, marital problems?

Participant 7: Marital problems, children at home, like there is mothers who must take care of the children. Because it is always a battle at home. Just to have somebody there to show them what to do, what is their options. And problems at home.

Discussion leader: So this will be in terms of support for the patients.

Participant 6: Yes, for the staff as well.

Discussion leader: Anything else you want to share?
Participant 6: I said maybe something like a chapel, uhm, a pastoral counsellor that is also here on a daily basis. If the patient decide to go there or the doctor wants to refer them.

Discussion leader: Spiritual.

Participant 6: Yes spiritual.

Participant 6: When I've worked at (Hospital name), they have what like they call a climate meeting. It is daily. When the patients come together, all the patients of the ward comes together in the ward, with the sister in charge, and they discuss, everybody got a chance to say what their goals is for the day. How are they feeling today and what are their goals for the day. And then they go on with the day. It just makes it easier for the sisters. They know what is going on in the wards with the patients. Because you do not have the time to go to every patient. You do not have the time to go to every patient every day and ask them how you are feeling today.

Participant 7: And if you give them medicine, I don't know, it does not always work. There is this queue in front of you, and sometimes they do not want to talk, it is personal.

Participant 6: Yes.

Participant 7: It is awkward, and you are under pressure to get them medicine out. And if you have set a goal for the day, it is their responsibility to attend a group.

Participant 6: (Afrikaans) you must take responsibility for your own illness.

Participant 5: Yes, it is a big problem. The patients expect us to do everything.

Participant 6: Yes, we need to teach them to take responsibility.

Discussion leader: Anything you would like to add? Let us summarise quickly. Okay, the dream will be to work 24 hours shifts, counselling for the staff, specifically a psychiatric nurse on an individual basis, you can make an appointment, and confidentiality on a one-to-one basis. And admissions, to have an extra psychiatric nurse that assist with the admissions. And to support with the patients. And Administration, in terms of the cardex writing, that there is a simpler way off, uhm, writing the cardex. In terms of the facilities, the patient transport, the gym, maybe a chapel on the premises, pastoral counsellors. A small shop, coffee shop like an ATM, a hairdresser, beautician, and adolescent ward, to separate the adolescence from the other patients. And the kitchen, more variety on the menu and they should also be in this dream I full-time social worker. To help with the marital problems, the children, taking care of their children at home, giving advice. That there is no drug abuse, patients with drug abuse admitted. If they are, it is really time consuming, and you feel it is unfair to the other patients. And the library, daily climate meeting patients taking responsibility for their own uhm, mental health. To state their goals, what groups are going to attempt? Anything that you would like to add?

Participant 6: There are adolescence, it does not need to be totally separate with the social worker, something like family therapy.

Participant 7: Yes.

Discussion leader: Okay, for now I am going to give each of you five stickers, and you can go to the board and decide, you can place a sticker next to where you think is the most important to you. So, you have to choose five that you feel in this dream will make it come true. Everybody will decide on their own.

Putting up of stickers.

Discussion leader: Okay, it seems that they are two places with three stickers each. The admissions, you feel that there need to be an extra psychiatric nurse for admissions that

there is more times for admissions and evaluations and it is also that there needs to be an extra adolescent unit, with a teacher and their own staff, strict rules and is is and other places with two stickers is counselling for the staff a psychiatric nurse for debriefing, counselling, in a confidential manner, and a chapel, with a pastoral counsellor's daily and spiritual support. The rest is Admin. In terms of the cardex, that there is less repetition. The hostel, the crèche, the patient gym and no drug abuse. And the library also. Anything else that you would like to add?

ADDENDUM M

EXAMPLE OF A TRANSCRIBE INDIVIDUAL INTERVIEW

INDIVIDUAL INTERVIEW II
DISCOVERY PHASE

Researcher: What actions from colleagues or supervisors makes you feel most supported at work?

Participant: When a doctor shouts at you, the supervisor will go into the matter and supports you. If you are in the wrong, they will show you the right way and if you are right, they will stand by you and take up your case with the relevant doctor.

Researcher: So, they support you in terms of acknowledgement and informal training?

Participant: Yes, and uhm, if you are not feeling well, or uhm, you are sick, and they know to which doctor to refer you that is good, they do so. If you just need some medication that you can get without prescription, they will also give advice in that regard. They are like a close family.

Researcher: So, they also attend to you physically when you are ill by referring or prescribing, uhm, medication.

Participant: During my (personal challenge), nobody ever was judgemental towards me, they have been just supportive. Also, when I was promoted to a senior post they mentored me up to a stage that I could go on on my own. During weekends and every afternoon when I'm alone in charge, of the hospital, they make me feel really in charge and respect the decisions I make in their absence. If there is any correcting measures that needs to be done regarding my interventions, that is done respectively and consultatively.

Researcher: So, uhm, you feel trusted and respected?
Participant: Yes, by senior and junior staff.

Researcher: Anything else in terms of support?

Participant: The government expects my company, uhm, my hospital to be involved in programmes, uhm, like reach out programmes, to uplift disadvantaged neighbouring communities and I identified a home, which is approximately twenty-five kilometres from

us. My supervisors welcomed the idea, and up to this stage, I am the coordinator thereof.

Researcher: Please tell me more about this home.

Participant: The home is catering for poor families, orphans and HIV positive people making use of volunteers.

Researcher: In other words your hospital is also supportive to the community, which makes you feel valuable, uhm, it offers staff members the opportunity to get involved?

Participant: Yes.

Researcher: Anything else?

Participant: My staff is very cooperative and it is easy with their support to implement the policies of the hospital to the best functioning and desired standards.

Researcher: Anything else that you want to add in terms of actions from colleagues that you experience as being supportive?

Participant: No, uhm, I think that is all.

DREAM PHASE

Researcher: Dream into the future and imagine this organisation giving you the best possible support at work, uhm, please describe this dream to me.

Participant: I'm nearing my retirement, I will be sixty next year, so, uhm, my dream is not so high. I can only dream seeing myself still working in this hospital for the next five years in order to accumulate better pension benefits as costs of living is going higher and higher.

Researcher: Yes, uhm, can you describe any wishes for me in terms of support?

Participant: I must stay positive in my attitude towards life. I must also look after my health, uhm, if possible join a gym and eat healthy. Presently I love my sugar and my

salt in food and think I must reduce that a bit.

Researcher: I have the same problem.

Participant: I also have to do regular pap smears and mammograms as my age falls within risk brackets. I will also have to minimise my stress at home with my (children) that don't look like having any direction or luck in life. I must just live my life.

Researcher: It sounds to me as if you have goals and dreams for yourself in terms of your own health and stress. Can you think of any dreams uhm, relating to workplace support?

Participant: I must continue to work hard and keep up my standard at work so that my employer can continue seeing me as an asset and want to keep me in the employment. I must also work harmoniously with everybody in order for people to enjoy my company and will want to continue working with me.

Researcher: So, uhm, it sounds as if you want to continue receiving, uhm, respect and appreciation?

Participant: Yes.

Researcher: Anything else?

Participant: Yes, I am a strong believer in our Creator, so I pray everyday that my dreams and wishes come true and only He knows what the future holds for us.

Researcher: It sounds as if you rely heavily on God for personal support?

Participant: Yes, very.
Researcher: Anything else, more dreams?

Participant: No.

ADDENDUM N

EXAMPLE OF A TRANSCRIBED REFLECTIVE INTERVIEW

TRANSCRIPTION REFLECTIVE INTERVIEW 2

DISCUSSION LEADER: How was it for you to be part of this core group, this morning?

RESEARCHER: Uhm, I clicked something when I stood there, and (Name) summed it up for me beautifully. Everything she said was what I was thinking; it is a process, the feeling of positive after discovery, and the dream. Uhm, we saw it last time, and today as well. Feeling positive, saying this and this and this is what we have, and then the dream phase, for some reason or another, maybe what (Name) said is that it (dream phase) highlights what they don't have, or, ja, how unrealistic it is or they can't have it. And I was also wondering if you could go on with the process, what would that change again? If you could design and implement (delivery phase), then they would see that the dreams, or some of their dreams might come true.

DISCUSSION LEADER: So, how was it for you to stop after the dream phase?

RESEARCHER: Yes, uhm, I think you feel a void, a need to carry on. (Name) also asked, will we communicate this. An I think they have that need to go further, and feel that they are heard, somebody is giving attention to them.

DISCUSSION LEADER: How did working in this context influenced the process for you?

RESEARCHER: Uhm, I don't know, uhm, I am not that clued up with the process yet. We had only the two, and it was quite the same as the previous one. We have discussed the three seating arrangements instead of the two, and I do not think it influenced much. We wanted participants to have the on-on-one interviews, and both times, it became a discussion. The felt that they could speak freely and they seemed like they enjoyed it. Uhm, they could be open with one another.

DISCUSSION LEADER: And how, in terms of you working at the facility, how did that influence the process for you?

RESEARCHER: Uhm, JA, I think that they feel that are comfortable, kind of, it is not like a social. I think this venue is connected with training because it is at work, JA, and then you are kind of in another role. If it was in a restaurant or coffee shop, it is not viable, but maybe everybody would have been more relaxed, to talk, feel more social. I am not sure if we would have gathered other themes than we did here, I do not think that

working here really influenced the themes.

DISCUSSION LEADER: Which participant made you feel least comfortable?

RESEARCHER: No one actually.

DISCUSSION LEADER: And more comfortable?

RESEARCHER: (Name), because she really summarised what I was feeling, in terms of the process. How they were feeling at the beginning, and what they were feeling at the end, and what they felt like after the dream phase, yes, she summed it up nicely.

DISCUSSION LEADER: In which way did you feel she was helpful?

RESEARCHER: She had other experiences, working in another setting, and I think she could compare, JA, and just highlight some thoughts that I had.

DISCUSSION LEADER: What thoughts did you have?

RESEARCHER: That, it is interesting to connect the process of discovery, dream, with how they are feeling, very positive or a bit more negative or like I said, our dreams are unrealistic, and I never connected, I thought it was because of the information and the themes that came out, that maybe it has something to do with the process.

DISCUSSION LEADER: And the impact on you?

RESEARCHER: Uhm, JA, I could agree with a lot of things they said. JA, I think once or twice I may have added, because I know where they are coming from. I understand what they are saying.

DISCUSSION LEADER: Can you give me an example?
RESEARCHER: Like the cardex, they suggested ticking meds given, and the meals, uhm, it did came up later, the meals for the patients, it is a lot of repetition, and I think I wrote in before they actually mentioned it, that you must write three times in the cardex.

DISCUSSION LEADER: Uhm, uhm. How did you manage that?

RESEARCHER: I, I was aware that I am adding now, while I was doing it. JA, I am not sure if it was a suggestion, because sitting here (where the participants sat) you can read what I am writing, and I am sure they added, or they mentioned it when they saw it written there. So, JA, I am not totally objective, because I work here, in this environment, I understand what they are saying, I understand their needs, uhm, and almost everything they said I can identify with.

DISCUSSION LEADER: So, how did you manage that?

RESEARCHER: I tried to be objective, uhm, I did not obviously stood there and agreed or inspired them, uhm, and I really tried to be neutral.

DISCUSSION LEADER: And you also get an independent people (Discussion leader), to facilitate the process, you were only writing, you were not that involved. To what degree do you think the setting impacted on the dynamics of the process?

RESEARCHER: I am not sure because I have not experienced the process in another setting, as I said, I think the same themes might have emerged; maybe people would have been more comfortable, more relaxed, more open to talk in another setting. They are well known to each other and they looked quite comfortable.

DISCUSSION LEADER: What findings surprised you?

RESEARCHER: Uhm, uhm, let me think. Oh, JA, in the dream phase, the social worker, I was just wondering how liable that is, uhm, I was thinking it is a psychiatric, like some of the scope that they mentioned, I was thinking it was psychiatric nurses responsibility too. Uhm, the social worker, if we dream, it is not here to take over psychiatric nurses work. So, I could not agree with that. May be on a part-time basis or on a consulting basis.

DISCUSSION LEADER: What findings did give you a negative emotion?

RESEARCHER: JA, the others, there was not really a negative reaction, it is just that uhm, I felt some is, but it is a dream phase so we encourage them to dream, to go wild, so, we wouldn't want them to be realistic and think how implement able it can be. Uhm, JA, like the chapel, uhm, the pastoral worker on a part time. JA, but it is not for me to think what is implemented able or not. It is not my place.

(Laughter)

DISCUSSION LEADER: It is more like reflecting while you were busy.

RESEARCHER: JA.

DISCUSSION LEADER: What findings gave you a positive feeling?

RESEARCHER: Not really the findings or the things that we identified, just, when we had tea, I asked them how is it, how was it and they said it was positive. It reminded them of the positive, it reminded them. I think they summarised it again beautifully.

DISCUSSION LEADER: To what degree were the findings similar or dissimilar to your thoughts prior to today's session?

RESEARCHER: I did not have any thoughts before today. My thought was on the previous data collection (small core group inquiry) and it was a lot the same, in the discovery and dream phase. I really did not have any expectations, I hoped for new information and new things. In the dream phase, we did get a few.
DISCUSSION LEADER: And which part impacted on you?

RESEARCHER: On me? Uhm, I think when I realised that the way of doing Appreciative Inquiry and the process ma be can have an impact on how they are feeling, and it is important where you stop the process before they leave, if they left maybe before the dream phase, it is different than now. The way they are feeling, the way they are going home.

DISCUSSION LEADER: So, what would you do differently from what you have learned, in future?

RESEARCHER: I am not sure if you can change the discovery and dream phase around and if that can work, if it is possible. Uhm, maybe just summarise, bring the discovery phase just in at the end, uhm, summarise that quickly, just to remind them of all the good stuff.

DISCUSSION LEADER: What other background valuables might have influenced how the participants reacted?

RESEARCHER: I think the demographics, uhm, they are well known to each other, two are day staff, the other night staff, and I still think we have a one sided view of things. My selection criteria, I would have hoped for, to get different participants. Uhm, say, the selection criteria said psychiatric nurse, for future more night staff.

DISCUSSION LEADER: So, you felt that the one psychiatric nurse from the night staff was not enough, you would have preferred than one.

RESEARCHER: Yes.

DISCUSSION LEADER: What type of ethical issues did you encounter during today's session?

RESEARCHER: I told (name) tell everybody, go and tell, and yes, that is unethical. We did have confidentiality; I did remind them of that. They do not need to discuss or tell anybody.

DISCUSSION LEADER: How did you handle this ethical issue?

RESEARCHER: If I remember correctly, I did interrupt myself and say yes, but it is confidential.

DISCUSSION LEADER: Yes, in your opinion, how did the ethical issues impact the participants during this session?

RESEARCHER: Uhm, when I got consent, I stressed confidentiality clearly, I think that might have given them security and when I come around asking them, it might have given them trust, because when they signed consent, and again when I came to the demographic information I stressed the confidentiality, I stressed that a lot.

DISCUSSION LEADER: What political issues did you encountered before, during and after this session?

RESEARCHER: Uhm, not political, much more practical, it was difficult with the invitations to get a group of people together on the same time, everybody's got their own lives, their own routine, arrangements and I really struggled to get them together on a certain date, to participate. Uhm, JA, I did not experience negativity, only

unavailability.

DISCUSSION LEADER: And how do you think did it impact on your findings?

RESEARCHER: Uhm, JA, I still feel like that those who were willing to come gave a slighter other view than, say everybody that did come.

ADDENDUM O

EXAMPLE OF FIELD NOTES

NR 2 ①

14/7/2010 Core Group Interview Fieldnotes:

B
A C

One of the participants cancelled the morning of the interview. Participant C was ± 5 minutes late.

Researcher introduced herself / others. Discussed title & purpose Workplace supports. Reason for selection. Ethics: Confidentiality

* Discovery phase:
- Discuss in a group of 3 "What do you experience as support in the workplace?"

Process notes:
B is the silent participant although she does participates and shares at times. She remains engaged by making eye contact with the group. She is also the only participant that is working night duty.

Seems to take the lead, she is confident and facilitates the discussion.

Dream phase:
- Discussion with 3 members went very well.
- Placed 3 stickers at Admissions: Extra psych nurse
" Addolescent unit seperately
2 stickers Counselling for staff
" Chapel
1 sticker: Admin, library, gym and no substance/drug abuse on the premises.

Termination phase: All 3 participants stated that it was positive

and they became aware of what worked in terms of support already.

C felt very optimistic during the discovery phase but more negative during the dream phase as she questioned if it was realistic and if changes will happen.
She asked at the end if this will be given through to management.

ADDENDUM P

LETTER FROM EDITOR

Marina van der Merwe Cell: 083 376 7367 e-mail. marina.vandermerwe@sita.co.za

21 September 2010

Aan wie dit mag aangaan

Ek, Marina van der Merwe, ID no. 680420 0110 087, verklaar hiermee dat ek die taalversorging van Mariette Swart se verhandeling gedoen het.

Ek het 'n sertifikaat in redigering en taalversorging aan die Universiteit van Pretoria voltooi, en het meer as 17 jaar ondervinding in die bedryf. Ek is tans (in 'n permanente posisie) as taalversorger werksaam by SITA (State Information Technology Agency), waar ek al die afgelope 12 jaar vir die taalversorging van dokumentasie verantwoordelik is.

By voorbaat dankie

Marina van der Merwe

(083 376 7367)