ENHANCING THE THERAPEUTIC ROLE OF REGISTERED NURSES IN A CARE-AND-REHABILITATION FACILITY

by

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Declaration

I, Anna Ntoki Mofokeng hereby declare that the dissertation submitted for the degree Magister Societatis Scientiae in Nursing at the University of the Free State is my own independent work and has not been previously submitted by me for a degree to another university or faculty. I further waive my copyright of the dissertation in favour of the University of the Free State.

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for the fulfilment of the degree Master of Social Science (Nursing) in the School of Nursing, Faculty of Health Sciences at the University of the Free State

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Dedication

This work is dedicated to my Heavenly Father who guided me in a practical way and allowed our relationship to grow much deeper, reminding me in a loving way that I am what I am, through Him.

I also dedicate this study to my late parents Mr. Motlana K. Mofokeng and Mrs. Alina Mofokeng, who were my pillars of strength.

To all people living with an intellectual disability, their families and friends.

Young researchers are the foundation of the solutions for problems in health care settings. This work is dedicated to all young researchers with a big dream of changing their setting, country, the continent and the world. It can be done.

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Abstract

Registered nurses, as frontline health care providers, render nursing care to people with intellectual disabilities in care-and-rehabilitation facilities. It is their responsibility to deliver therapeutic nursing care by creating a therapeutic milieu for people with intellectual disabilities in long-term wards. They are however challenged by various difficulties addressing these needs in unconducive environments. The purpose of this study was to explore and describe the recommendations of registered nurses to enhance their therapeutic role in care-and- rehabilitation facilities.

The study followed a qualitative, explorative and descriptive research design. A purposive selection of participants (n=22), consisting of registered nurses working in a care-and-rehabilitation facility at the Free State Psychiatric Complex, was conducted. Nominal group discussions were administered by an experienced facilitator that explored the registered nurses' recommendations on their therapeutic role in a care-and-rehabilitation facility. Four nominal group discussions were held with 22 registered nurses that produced 66 statements.

Van Breda's multiple group data analysis steps were followed to analyse the data collected. Themes and sub-themes were identified from data gathered during the nominal group discussions. Seven themes emerged, namely communication, staff support, healthcare environment, care delivery, education, legislative and policy framework as well as resources. Each theme produced relevant sub-themes.

The findings led to specific recommendations related to the themes and sub-themes. These could guide the various stakeholders to assist registered nurses to render competent and comprehensive therapeutic nursing care for people with intellectual disabilities in care-and-rehabilitation facilities.

Keywords*:* registered nurse, therapeutic role, intellectual disability, care-and-rehabilitation

List of abbreviations

AAIDD	-	American Association on Intellectual & Developmental Disabilities
ADL	-	Activities of Daily Living
ANA	-	American Nursing Association
APA	-	American Psychiatric Association
DoH	-	Department of Health
FSDoH	-	Free State Department of Health
FSPC	-	Free State Psychiatric Complex
HRSEC	-	Health Science Research Ethics Committee
ID	-	Intellectual disability
IQ	-	Intelligence quotient
NGD (‘s)	-	Nominal group discussion(s)
NGT	-	Nominal group technique
PWID’s	-	People with intellectual disabilities
RN (’s)	-	Registered nurse(s)
SANC	-	South African Nursing Council
WHO	-	World Health Organisation

Operational and conceptual definitions

Care-and-rehabilitation facility, according to the Mental Health Care (Act 17 of 2002), means a place for recovery and rehabilitation for individuals to return to optimal functioning or to become independent. A care-and-rehabilitation facility means a long term care setting for the rehabilitation of people with intellectual disabilities to learn skills, receive support, safety and health promotion (Anjali, 2006; Cook, 2013). In this study the concept means a long term care setting in a mental health care hospital to support people with intellectual disabilities by promoting their health, functional abilities as well as their physical, emotional and social wellbeing.

Registered nurse (RN) is a registered, qualified person competent to practice independently comprehensive nursing at the prescribed level, and who is capable of assuming responsibility and accountability for such practice according to Section 30(1) of the South African Nursing (Act 33 of 2005).

A psychiatric nurse is described by the SANC (R. 880) as a registered nurse who obtained a qualification in psychiatry and is registered as a psychiatric nurse. In this study, the researcher will refer to a psychiatric nurse as a registered nurse, with or without a psychiatric qualification, but working in a care-and-rehabilitation facility.

Therapeutic role means a nurse's responsibility to engage with patients by providing a supportive and safe environment that enhances social interaction, participation, opportunities to acquire skills and promote optimal functioning in activities of daily living (Kneisl & Trigoboff, 2009:776; Soderback, 2009:37). Furthermore, Videbeck (2020: 224,225,229) distinguishes between four therapeutic roles, that is: teacher, caregiver, advocate, and parent surrogate. In a care-and-rehabilitation ward, the RN may fulfill all these roles. In the study, it means that the responsibility of a registered nurse (RN) is to improve the quality of life for people with intellectual disabilities by delivering therapeutic nursing care through various therapeutic roles.

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CHAPTER 1

Overview of the study

1.1 Introduction and background

The term *intellectual disability* was previously known as *mental retardation* and is a diverse set of impairments that affect the cognitive, educational and social abilities of an individual (AAIDD, 2010). Intellectual disability (ID) refers to the disorder that is characterised by sub-average intellectual functioning and impairments in the adaptive behaviour of an individual (AAIDD, 2010). The onset of the disorder is during the developmental period before 18 years (Harris, 2006:9; Rubin *et al*., 2016:19). Adaptive behaviour includes conceptual, social and practical skills. The various levels of severity are defined according to adaptive functioning and IQ scores. Severity levels may be mild, moderate, severe or profound (APA, 2013).

The World Report on disabilities states that 15% of the world population has some form of disability and 2%-4% experience difficulty in physical and intellectual functioning (WHO, 2011:1). The prevalence rate of people with intellectual disabilities (PIWD's) in South Africa is not certain due to unreliable information in South African statistics. The estimated intellectual disabilities prevalence rate in South Africa's rural areas in 2007 was 3.6% (Foskett, 2014) which is higher than in developed countries (Adnams, 2010:436-437). In the Free State province, it is 11%, which is the highest compared to other provinces in South Africa (Census, 2011). PWID's constitute 2%-4% of the total population in South Africa. The level of severity of PWID is mostly mild, 20% is moderate, and 5% have severe and profound intellectual disabilities (Uys & Middleton, 2010:542).

Community-based residential areas care for PWID's, although people with a severe and profound intellectual disability need specialised services. This includes total nursing care, psychiatric services, medical care, support, screening and assessment

(WHO, 2007:39-42; Fitzgerald & Sweeney, 2013:32-38; McKenzie *et al*., 2014:45-54). Care-and-rehabilitation facilities care for persons with intellectual disabilities according to the Mental Health Act (No. 17 of 2002). They also provide long term care to develop the capabilities and skills of PWID's to achieve an optimal functioning level in daily living activities (Anjali, 2006; Cook, 2013:23).

Patients admitted for long term care are mostly severely and profoundly intellectually disabled. In-patients with severe intellectual disability need assistance with self-help skills and 24-hour supervision, but they are still able to learn certain skills. Profoundly intellectually disabled in-patients require a high level of assistance and intensive labour from the nursing staff with daily living activities. They also need specialised care (APA, 2013:36; Sadock *et al*., 2015:1120; Rubin *et al*., 2016:7).

The Free State Psychiatric Complex (FSPC) is the only psychiatric hospital in the Free State province and a part of the Northern Cape province that renders specialised services for PWID's, according to the Mental Health Act (No. 17 of 2002). The hospital is divided into two sections, namely the psychiatric section, as well as the care-and-rehabilitation centre. Altogether the FSPC consists of 760 beds, with an average bed occupancy of 664 patients (FSPC, 2016). Also, the nursing corps consists of 185 registered nurses, with and without psychiatric qualifications, 33 staff nurses and 207 nursing assistants (FSPC, 2016).

The section for intellectual disability inpatients consists of 16 wards and the overall number of in-patients is 407. Classification of these wards is threefold. There are ten (10) wards for mobile PWID's, five (5) wards for immobile PWID's and one (1) medical ward with patients with severe, profound intellectual and physical disabilities. Each ward has a bed capacity of 25-30 patients. There is a nurse-patient ratio of 2:30. This ratio comprises of staff nurses and nursing assistants. There is a high registered nurse (RN)-patient ratio of 1:30 for each ward. This is applicable to day duty. Furthermore, the nurse-patient ratio on night duty is either 1:30 or 2:30 in the wards and consists of staff nurses and nursing assistants. But, there is only one registered nurse allocated for four wards on night duty in relation to the psychiatry section. In that section, the nurse-patient ratio is 1:20 up until 1:30 and registered nurse-patient ratio is also 1:20 up until 1:30 (FSPC, 2016).

Services provided for the institutionalised PWID's should include basic nursing care, a comprehensive needs assessment, mental health care services, multidisciplinary health services, support and therapeutic stimulation programs. PWID's are rehabilitated to improve their emotional, physical, social and intellectual functional levels (Gates & Barr, 2009:19-20; Gates & Mafuba, 2015:19; Rubin *et al*., 2016:10). However, the World Health Organisation (WHO) reported that people with intellectual disabilities (PWID's) receive inadequate or poor health care services that does not meet their health care needs (WHO, 2007:9; WHO, 2010:6). Research indicates that general conditions of PWID's remain mostly undetected. They receive incorrect, or no, therapeutic nursing interventions from the nursing staff and consequently lose their remaining capabilities (Harris, 2006:162; Rubin *et al*., 2016:10). A previously conducted study also indicated the need to develop authentic leadership among nurses in care-and-rehabilitation facilities. The developmental initiative needs to remind them of their values in the work environment in order to meet the therapeutic needs of PWID's (Venter & Jacobs, 2014:31).

1.2 Problem statement

Registered nurses have the responsibility to create and manage the therapeutic environment. This can influence the total nursing care of people with intellectual disabilities because they have 24-hour contact with the patients. They are able to manipulate the social and physical environment by using resources in the environment to promote optimal functioning in daily living activities of PWID's (Kneisl & Trigoboff, 2009:3, 246, 786-788). Registered nurses have moved away or neglected their therapeutic role in the wards. They spend less, or no, time on therapeutic interactions with PWID's. Their primary focus changed to the administration of medication, to control the medical and behaviour problems associated with mental disorders and to deal with the increased documentation and paperwork. The PWID's are most often ignored, isolated, disengaged and inactive in the wards. The PWID's are not developed to learn activities of daily living (ADL) and not stimulated to achieve their maximum potential (Kneisl & Trigoboff, 2009:776; Fisher, 2014:264-270; Goulter *et al*., 2015:444-456).

The current low registered nurse-patient ratio makes it difficult for the implementation of individualised therapeutic interventions based on the PWID's function levels. Previous studies also indicated a lack of therapeutic skills, knowledge, and understanding as well as negative attitudes towards PWID's as a challenge of the RN's in care-and-rehabilitation facilities (Armitage, 2012:14-18; Browne *et al*., 2012:839-843; Kathleen, 2012:340-341; Taua *et al*., 2012:163-170). Emotional exhaustion and increasing workload because of nursing staff shortages result in inadequate and poor health care services rendered to PWID's (Pazargadi *et al*., 2015:551-557; Ray *et al*., 2013:255-267).

Consequently, the RN's therapeutic role needs to be reinforced (Doody *et al*., 2012:275-286). There is a need for awareness to enhance the understanding of, and a change of attitude towards, PWID's (Jenkins, 2012:85-95; Golding & Rose, 2015:116-129). RN's also need training to develop their confidence and competence to render quality health care services, meeting the health care needs of PWID's (Wermer & Stawiski, 2012:291-304; Sechoaro *et al*., 2014:1-9).

Therefore, in this study, the researcher will investigate the ideas from RN's to enhance their therapeutic role in care-and-rehabilitation facilities.

1.3 Research purpose

The purpose of this study was to explore and describe the recommendations of registered nurses to enhance their therapeutic role in a care-and-rehabilitation facility.

1.4 Research question

This study tried to answer the question:

> What do the registered nurses recommend to enhance their therapeutic role in a care-and-rehabilitation facility?

1.5 Paradigm

A paradigm perspective is a world view and general perspective on the complexities of the real world. It is the way the researcher views the study (Polit & Beck, 2008:13; De

Vos *et al*., 2011:41; Polit & Beck, 2018:201, 247). A constructivist worldview, often combined with interpretivism, is an approach whereby researchers seek understanding of the world in which they live or work in. Researchers try to understand and interpret multiple meanings that individuals hold related to their daily interactions, activities and real situations (Creswell, 2009:9; Leavy 2017:13; Mertens & Wilson, 2019:130). The researcher used a constructivist approach, relying on the views and ideas of RN's in a care-and-rehabilitation facility constructing the enhancement of their therapeutic role. The researcher responded to the basic philosophical questions in the following way, namely:

1.5.1 Ontology

Ontology is the branch of philosophy responding to the question of what the nature of reality is (Botma *et al*., 2010:41). Constructivists assume that individuals construct their own reality by reflecting on lived experiences (Mertens & Wilson, 2019:132). For this study, the researcher explored the RN's ideas on how to improve their therapeutic role in a care-and-rehabilitation facility (as the real setting) by providing a description thereof.

1.5.2 Epistemology

The philosophical question supposes a certain relationship between the researcher and those or that being studied (Polit & Beck, 2017:103; Polit & Beck, 2008:13). Interaction between the researcher and participants may create knowledge and meanings related to their "lived experiences" (Mertens & Wilson, 2019:132). The use of nominal groups, as the selected data collection method, enabled the researcher to construct the registered nurses' recommended ideas to enhance their therapeutic role in a care-and-rehabilitation facility. In this way, a better understanding of the therapeutic context was obtained through meaningful nominal group discussions.

1.5.3 Methodology

Another central philosophical strand is the strategy a researcher uses to obtain knowledge for the study (Polit & Beck, 2017:112; Polit & Beck, 2008:13). The researcher utilised a qualitative, consensus study method by means of the nominal

group technique. In such a way the recommended ideas of the registered nurses were obtained to enhance their therapeutic role in a care-and-rehabilitation facility.

1.6 Research design

A qualitative, explorative, descriptive research design was used. The nominal group technique, a useful consensus method in exploring and understanding the meaning that individuals ascribe to a social or human problem, was used (Polit & Beck, 2017:98; Creswell, 2009:4; Botma *et al*., 2010:251). A descriptive (comprehensive description of individual perspectives), explorative (examination of the nature of the topic) and qualitative design was deemed the applicable research method to capture the truth of this study's phenomenon (Polit & Beck, 2017:102; Polit & Beck 2008:21, 237-238). The researcher explored and described the RN's responses to enhance their therapeutic role in a care-and-rehabilitation facility.

The consensus method determines the extent to which a group of participants agree on a particular topic. One type of the consensus methods is the nominal group technique (NGT) (Botma *et al.,* 2010:251). The NGT has the benefit of stimulating the generation of creative ideas and collaboration amongst participants (Delbecq *et al*., 1975). The researcher endeavoured to understand the RN's recommended ideas to enhance their therapeutic role in a care-and-rehabilitation facility by means of the NGT. A short description of the definition of therapeutic roles was provided to all participants before the start of the NGT process. The therapeutic role was described as a goal-directed action whereby a nurse engages with a patient in a meaningful and purposeful manner to reach a specific goal. The responsibilities of nurses include the creation of a supportive and safe environment (milieu) and opportunities to acquire skills by participating in activities of daily living (ADL) to promote optimal functioning and enhance social interaction with PWID's. This explanation was given to assist the researcher to eliminate participant confusion. Clarity was given on their therapeutic roles in a care-and- rehabilitation facility to support the consensus process.

1.7 Research technique

The nominal group technique (NGT) values the individual's contributions, during the group process, after the facilitator poses a single question. It is a non-hierarchical method ensuring independent participation of each member during group discussion (Lennon, Glasper & Carpenter, 2012). The NGT aims to reach an agreement amongst group participants during a structured group discussion. The process consists of four stages, namely generating ideas, round-robin, clarification and ranking main ideas (Botma *et al.,* 2010:251). See Table 1.1 for the four stages of the nominal group technique**.**

The researcher used the nominal group technique to generate recommended ideas with the assistance of the registered nurses providing care for PWID's in care-and-rehabilitation wards. The researcher, as registered nurse in charge of a ward for PWID's, did logistical arrangements but did attend the NGD's due to her position. An experienced facilitator holding a PhD in nursing facilitated each group discussion and implemented all stages in similar fashion. One or more group discussions, comprising of 5-12 members each, is useful to researchers using the nominal group technique (Moule & Goodman, 2014:237).

1.8 Population

Population refers to the entire aggregate of people or cases the researcher will be interested in (Polit & Beck, 2008:337). The target population is the entire set of objects, persons or other single units of the study (Botma *et al*., 2010:124). For this study, the target population was the RN's working in wards in a care-and-rehabilitation facility within the Free State Psychiatric Complex (FSPC).

1.9 Unit of analysis

Unit of analysis refers to the possible members of the population that can be included in the study, using specific selection criteria (Polit & Beck 2008:338; Moule & Goodman, 2014:291). The researcher specified inclusion and exclusion criteria to purposively select registered nurses due to their appropriateness in answering the research

question. The unit of analysis consisted of 22 registered nurses that participated in four nominal group discussions.

1.10 Explorative interview

An explorative interview refers to a small study that the researcher conducts before the main study. The researcher therein, tests the study technique and research question, predicts problems with the implementation and evaluates the appropriateness for the participants (Polit & Beck, 2017:265; Polit & Beck, 2008:13; Green & Thorogood, 2009:57). The researcher implemented one explorative NGT group consisting of five participants. The researcher did only the first three steps of a NGT to test the research question and technique that were used as such in the study. Explorative interview was done by the researcher to familiarize herself with the research process. No data from the explorative interview were used in the final results of the study, because the researcher implemented only the first three NGT steps.

1.11 Data collection

Data collection or gathering refers to the researcher plan on how to implement the process to gather data, and it also refers to the research technique to be utilised (Botma *et al*., 2010:199). The researcher used NGT discussions that were facilitated by an experienced facilitator. The data was collected after approval to conduct this study has been granted by the University of the Free State's Health Science Research Ethics Committee, (Reference number: HSREC 44/2017, UFS-HSD2017/0301), the Free State Department of Health (FSDoH) and the hospital management (Refer to Annexure D).

Four NGT groups were held on four different Wednesdays, because it suited the wards. It limited disruption in nursing duties. A total of 22 participants formed part of the four nominal group discussions (NGD's) after they received information and gave informed consent (see Annexures B and C). The facilitator followed each stage of the NGT, as described in Table 1.1 below. More details of data collection will be discussed in chapter 2.

Table 1.1: Four stages of the Nominal group technique

Stages of NGT	Facilitator Responsibility	Participants Activities	Duration
Introduction (pre-stage)	- Welcoming participants - Explain the purpose of the study		5 minutes
1. Generating ideas	- Present the research question to the group - Provide papers and pens	- Silent reflection - Write a list of ideas or responses in silence independently	10-15minutes
2. Recording and sharing of ideas (Round-Robin)	- Write each idea or response on a flipchart - Give participants turns	- Feedback session - Mention their ideas or responses	Continue till saturation is reached
3. Group discussion	- Clarify each idea or responses - Read statement noted on flip-chart loud -Confirm for understanding -Write prioritized ideas on flip-chart	- No judgment of ideas or responses - Clarification of ideas - Prioritize ideas or responses in order of importance	30-45minutes
4. Voting and ranking ideas or responses	Provide five separate recording or voting cards	- Vote to choose five ideas or responses from the main list on flip chart privately - Rank from 1-5 on cards	Continue until a consensus is reached

1.12 Trustworthiness

Trustworthiness in qualitative research is the researcher's intention to maintain the quality of the research or study and to ensure that the findings reflect the truth (Polit & Beck, 2008:195; Moule & Goodman, 2014:191). The researcher enhanced trustworthiness in the study based on the following criteria:

1.12.1 Credibility

Credibility refers to the confidence in the truth of the data and the interpretation thereof in order for the reader to be able to believe its accuracy (Polit & Beck, 2008:539; Brink *et al*., 2012:172). The use of the NGT provides an opportunity for participants to verify the data and to reach consensus without the researcher's interference. The researcher enhanced credibility in the study by using an experienced facilitator to conduct NGD's. Furthermore, a registered nurse working in a care-and-rehabilitation facility rechecked the data and the opinion of an expert researcher on each step of the research process was sought.

1.12.2 Dependability

Dependability refers to the stability of the research data for some time. The same findings are supposed to be seen if the similar study is to be repeated (Polit & Beck, 2008:539). The researcher ensured that the research process is logical, well documented and audited (De Vos *et al*., 2011:420). The researcher transferred data collected from flip-charts to the computer and documented every part of the research process in detail. Data source triangulation was used as literature control to discuss the findings.

1.12.3 Confirmability

Confirmability refers to the objectivity and accuracy of the data, as well as being a true reflection of the information provided by the participants. The rechecking of the data collection process, including the flip-charts, were done for confirmation (Brink *et al*., 2012:173). The participants checked the accuracy of data captured on the flip-chart during NGD's with the facilitator, and the researcher utilised independent researchers

to conduct an enquiry audit to examine the data, findings, interpretations and recommendations. The supervisor also checked the documents, such as the audited documents.

1.12.4 Transferability

Transferability is the extent to which the research findings can be applied or transferred to other settings or participants (De Vos *et al*., 2011:420; Brink *et al*., 2012:173). The researcher ensured transferability by providing a comprehensive description of the research process and detailed data on all documents used in the research process. Any reader can evaluate, based upon whether the findings can be transferred to another context.

1.13 Ethical considerations

Ethical considerations mean that the researcher respect and protect human rights (Polit & Beck, 2008:170). The researcher adhered to the ethical issues by submitting a research proposal to the School of Nursing Evaluation Committee, the Health Science Research Ethics Committee (HRSEC), Free State Department of Health and hospital management to request permission to conduct the study (See Annexures A, D). All the stakeholders provided permission. Furthermore, participants were extensively informed about the study and their rights if they participate, before signing of the consent forms. The researcher adhered to the principles of respecting human dignity, beneficence and justice (Polit & Beck, 2012:152).

1.13.1 Respect of human dignity

The participants were free to voluntarily participate in the study; not forced by the researcher. The participants could also decide to withdraw from participating in the study at any time (Polit & Beck, 2008:171). The researcher provided participants with information about the study to ensure that they make an informed decision.

The study purpose, benefits, risks involved and the participant's rights were explained in an information brochure that was given to the participants (Polit & Beck, 2008:177). The researcher responsibility was to supply the participants with ample information

about the study. Thereafter, the participants gave their consent to participate in the study by signing a consent form (Refer to Annexure C). Beneficence was also recognised by the researcher.

1.13.2 Beneficence

Participant's information was kept confidential and not linked to a specific person. Therefore, the researcher kept the data collected in a locked cupboard after the study for reference. The data will be destroyed after five years (Polit & Beck, 2008:180). The participants were informed that the information they provided to the researcher during the NGD's is not accessible by people who are not part of the study. The researcher also maintained justice.

1.13.3 Justice

The participants should receive fair treatment from the researcher (Polit & Beck, 2012:155-156). The researcher recruited the participants in the wards by handing over the invitation letters with the information about the study. This happened by means of the area manager. RN's interested to participate in the study, signed the consent forms. Participant's selection was based on the inclusion criteria set for the study.

1.14 Data analysis

Data analysis refers to how the researcher organised, found meaning and interpreted the collected data (Polit & Beck, 2008:507). NGT combines qualitative and quantitative data analysis methods (Lennon, *et al*., 2012). The participants reduced and prioritised data themselves during the NGT group discussions.

The researcher organised the data into themes or categories to make sense and compared the data sets (Creswell, 2009:183,185) using the multiple nominal group data analysis processes proposed by Van Breda (2005:4). Therefore, the process was documented meticulously in chapter 2 to ensure optimal data accuracy.

1.15 Chapter summary

Chapter 1 provided a brief overview of the study. In this overview, the problem statement, research purpose and question, “What do registered nurses recommend to enhance their therapeutic role in a care-and-rehabilitation facility?” emphasized the importance of the study. The research design and technique elaborated on how this study was commenced. Additionally, actions on the population sample, pilot study and data collection itself, indicated who took part. It also showed how the study was conducted to ensure the accuracy of the findings. The researcher ended the chapter with a brief discussion on trustworthiness and ethical considerations.

Succeeding Chapter 1, Chapter 2 contains a detailed description of the study’s methodology. Chapter 3 presents the study findings, while Chapter 4 give a summary of the findings during data analysis.

CHAPTER 2

Research methodology

2.1 Introduction

In the previous chapter, the researcher gave a brief overview of the study, including the paradigmatic perspective. This chapter will provide the methods used in the research study. It will detail the following: research design, population, sampling, data collection, data analysis, trustworthiness and ethical considerations**.** For this study, the researcher used qualitative research and the nominal group technique as a consensus method to explore and describe the registered nurse's recommendations to enhance their therapeutic role in a care-and-rehabilitation facility.

2.2 Research design

Research design is defined as the purpose or plans to conduct research (Polit & Beck, 2017:98; Polit & Beck, 2008:66; Creswell, 2009:4; Moule & Goodman, 2014:170). Besides, Creswell (2012:20) and De Vos *et al*. (2011:109) describe research design as a specific procedure in the research process for data collection, data analysis, report writing and the method to address the research question. This researcher used a qualitative research design that is explorative and descriptive to address the research problem through participant consensus. This type of research is appropriate, because the researcher will explore and describe nurses' recommendations to enhance their therapeutic role in a care-and-rehabilitation facility. The aspects of the design are explained below.

2.3 Qualitative research

Qualitative research is concerned with exploring and understanding the problem or phenomenon (Creswell, 2009:4; Creswell, 2012:16,17,129). Furthermore, it helps to discover knowledge about the underlying meanings and experiences of the participants' viewpoints (Streubert & Carpenter, 2011:21; Yin, 2011:7; Brink *et al*.,

2012:121). The researcher focused on the participants' viewpoints and relied on their recommendations to obtain the needed information for the study.

2.3.1 Characteristics of a qualitative research design

A qualitative design comprises of the following common characteristics. It:

- Studies real-world events in a real-world setting;
- Involves collection, interpretation and presentation of data from various sources of evidence;
- Is flexible, elastic and capable of adjusting to what is being learned during data collection;
- Is representative of participants' viewpoints;
- Is holistic, striving to understand the whole;
- Allows the researcher to become the primary research instrument,
- Ensures that data is analyzed to give a description, and;
- Identifies themes by using text analysis and interpreting findings (Streubert & Carpenter; 2011:20-22; Yin, 2011:7; Creswell, 2012:13-18; Polit & Beck, 2012: 487).

2.3.2 Strengths of a qualitative research design

Qualitative research has some strengths as well as weaknesses. Strengths of a qualitative research design include the following. It:

- Explores the research problem and focuses on an in-depth understanding of the central phenomenon;
- Is flexible and can be modified anytime;
- Is relatively inexpensive compared to other research designs.
- Uses open-ended questions that yield a large amount of data, compared to quantitative research (Creswell, 2012:13-18; Babbie, 2013:353-357).

2.3.3 Weaknesses of a qualitative research design

The researcher relied rather on the participants' views than the literature review at the beginning of the study, and;

- The focus of the researcher is to address a single problem (Creswell, 2012:13-17).

Considering the purpose of the study, the researcher also adopted a descriptive and explorative design.

2.3.4 Descriptive design

A descriptive design is concerned with an in-depth description of individuals, groups, situations, events or activities, providing information related to the research question. This description has the ability to provide accurate information related to the individuals' situation or perceptions related to certain activities (Polit & Beck, 2008:763). The researcher wanted to describe the registered nurses' recommendations enhancing their therapeutic role when working in a care-and-rehabilitation facility.

2.3.5 Explorative design

Exploratory research aims to fill the knowledge gaps on a topic that is unknown, or to gain insights from different perspectives to generate new perceptions (Polit & Beck, 2012:18). This will lead to solutions that can be identified. The researcher explored the registered nurses' recommendations to enhance their therapeutic role in a care-and-rehabilitation facility to gain insight and understanding therein. An explanation of the research technique, used to obtain the research data, follows.

2.4 Research technique

The researcher chose the nominal group technique as one of the consensus methods to construct the multiple perspectives of RN's ideas related to the enhancement of the therapeutic role. Consensus methods base their results on a group's consensus. A group of people with the necessary expertise are brought together to achieve a consensus view (Botma *et al*., 2010:251; Harvey & Holmes, 2012:188-194; Moule &

Goodman, 2014:238-240). NGT is described as a small, structured and facilitated group discussion to reach consensus. It is a process used to generate information from a group of people to address the problem (De Vos *et al*., 2011:503; Harvey & Holmes, 2012:188-194). NGT is structured to follow a process of four stages to generate ideas, mainly with a manageable 5-12 members in a group. The process includes generation, recording, discussion and voting or ranking of ideas. The facilitator encourages all group members to participate in the NGD's. These sessions may last between 1-2 hours each (Delbecq *et al*., 1975; Van Breda, 2005:2; Botma *et al*., 2010:251; Moule & Goodman, 2014:237-238).

Four stages of the NGT include:

- Introduction;
- Stage 1: Generating ideas;
- Stage 2: Recording and sharing of ideas;
- Stage 3: Group discussion, and;
- Stage 4: Voting and ranking ideas (Delbecq *et al*., 1975; Botma *et al*., 2010:251-252).

NGD's were held on separate days between October 2018 and December 2018. Three of the four groups were conducted in the mornings from 10h00 to 12h30, and the last group was held from 13h00 to15h30. A facilitator with experience in NGT conducted the four NGD's. The advantages and disadvantages of NGT are discussed hereafter.

2.4.1 Advantages and disadvantages of the nominal group technique

An advantage of the NGT is that it is cost-effective to use, and requires minimal resources in preparation before the group discussions (Moule & Goodman, 2014:237-238; Dang, 2015:14-25). In this study, the researcher therefore encountered minimal expenditure and only had to buy stationery, such as flip-charts, papers and pens together with some snacks.

Another advantage is that the NGT stimulates creative thinking. It also touches on the knowledge, experience and skills of the participants. The facilitator engages the participants to generate information, together with solving the problem constructively

(Delbecq *et al*., 1975; Lennon *et al*., 2012). The facilitator allowed the participants to think, rethink and write their ideas independently with regard to the research question presented.

Time efficiency is also an advantage, because NGT is quicker to use and a large amount of creative ideas is generated within 1-2 hours for each completed group discussion session (Delbecq *et al*., 1975; Lennon *et al*., 2012; U.S. Department of Health, 2018). In this study, all ideas were recorded by the facilitator on the flip-chart. It was immediately visible to all group members to avoid missed ideas.

The round robin stage afforded individuals the time to clarify their ideas listed. It helped to minimise misinterpretations. Each participant expressed the logic behind the ideas and supported it freely without any arguments from the group members. NGT is a facilitated process that requires the use of an experienced facilitator who conducts NGD and prevents group domination by specific group members (Delbecq *et al*., 1975; Lennon *et al*., 2012; McMillian *et al*., 2016). The facilitator gave each participant an equal opportunity to clarify their ideas.

Group discussion encouraged interaction and dialogue amongst the participants. The final stage allows participants to prioritize ideas democratically and weigh them against each other (U.S. Department of Health,, 2018). Dang (2015:14-25) and McMillian *et al*. (2016) mentioned that the results are produced instantly after each NGD. This gives the participants a sense of accomplishment and closure. In this study, participants appreciated the prompt feedback when they saw their final rankings of priorities. These final rankings also assisted the researcher with data interpretation.

2.4.2 Disadvantages and limitations of NGT

NGT requires some preparations before the group discussions (Delbecq *et al*., 1975; Moule & Goodman, 2014:237-238; Dang, 2015:14-25). These preparations include the organising of a room to accommodate participants, tables have to be arranged in a U-shape, together with the provision of stationery, such as flip-charts, pens and voting cards (Delbecq *et al*., 1975; Varga-Atkins *et al*., 2011; U.S. Department of Health, 2018). The preparations by the researcher comprised of the organization of a venue that was accessible to all the participants from the wards, stationery, recruitment of

participants and the availability of an experienced facilitator from the University of Free State.

Unfortunately, some participants failed to attend the arranged group discussion due to other obligations; despite the preparations carried out by the researcher before the NGD's. The specific time and date allocated for attendance of each participant could also have limited attendance of participants. Group size was limited between 5-12 members. Participants were also free to withdraw from the NGD at any stage, which may eventually impact on the group size (Lennon *et al*., 2012; Moule & Goodman, 2014:237-238; Rice *et al*., 2018). However, the four NGD's, comprising of 22 participants, were adequate; according to the literature.

Lennon *et al*. (2012) added that NGT's are restricted to a single topic and purpose. The participants only receive one opportunity to participate in an NGD. According to Dang (2015:14-25), NGT is a structured process with specific steps that the facilitator and participants must follow. In this study, the facilitator followed the NGT steps to collect data in each NGD.

The NGD occurs in a specific time frame managed by the facilitator. The full development of ideas may be limited by a restricted time allocated for each NGT step (Varga-Atkins *et al*., 2011; U.S. Department of Health, 2018). However, the facilitator allowed the participants to think about the question posed to them and also write their ideas, and additional ones, down.

The participants need to be physically present for a face to face discussion (McMillian *et al*., 2016). Lack of anonymity in a face to face NGD may impact on the participants. They may feel uncomfortable and reluctant to express their ideas verbally (U.S. Department of Health,, 2018; Dang, 2015:14-25). Participants in this study seemed to be comfortable to participate; even though they met face-to-face in a group.

In the NGT process, the same research question was stated in each group. A different number of statements may be generated from the groups, varying between them. However, bigger groups are inclined to generate more statements and obtain higher scores compared to smaller groups (Van Breda, 2005:2-3; Moule & Goodman, 2014:237). The last NGD in the study consisted of four participants. Nevertheless, the

group generated more ideas compared to the other groups, with a higher number of participants.

The process of data analysis is time-consuming to confirm and interpret data collected (Lennon *et al*., 2012; U.S. Department of Health, 2018; Rice *et al*., 2018:1-9). It includes capturing a whole number of ideas on a computer from the flip-chart that needs to be analysed. The researcher followed data analysis steps stipulated by Van Breda (2005:6-7). The effectiveness of the NGD depends on the facilitator skills and experience (Varga-Atkins *et al*., 2011; Dang, 2015: 14-25).

2.5 Facilitator of the NGT

The NGT process requires the skill to generate and clarify a large number of ideas from group members. A highly trained, skilled facilitator is needed to conduct the NGD's, minimising dominance by some group members. The facilitator has to involve all group members equally and allow them to freely participate without any influence from other members of the group. The participants' recommendations are recorded immediately by the facilitator. A reflection of their own words has to be captured on a flip-chart to avoid omitted information (Delbecq *et al*., 1975; Dang, 2015:14-25). In the study, the facilitator was a researcher holding a PhD, who had training and experience conducting NGD's. The NGT process was introduced and the research question was presented to the participants by the facilitator. The participants were provided time to think about the research question and jot down their recommendations without any interruption. The facilitator also ensured that participants signed consent forms before each NGD.

2.6 Population

It is important to identify an appropriate population for a specific study, based on their expertise with regard to the topic. The population is an entire set or a group of people that possess specific characteristics that the researcher is interested in to address the research problem (De Vos *et al*., 2011:223; Streubert & Carpenter, 2011:142). Target population refers to the entire, or aggregate, population that meet the stipulated inclusion criteria (Polit & Beck, 2008:337; Botma *et al*.,

2010:124). The target population was RNs, purposefully selected on the ground of working in a care-and-rehabilitation facility at the Free State Psychiatric Complex.

2.7 Unit of analysis

Unit of analysis is the possible members of the population that can be included in the study, using specific selection criteria or having common characteristics (Babbie, 2013:99; Moule & Goodman, 2014:291). The researcher established the inclusion criteria to guide the selection of participants. The researcher undertook purposive sampling after the participants met the required inclusion criteria. This study unit of analysis comprised of 22 registered nurses, consisting of both males and females.

2.8 Purposive sampling

Purposive sampling is an approach used to select individuals, purposefully, that will benefit from the study (Polit & Beck, 2012:517). A purposive selection includes participants with knowledge and experience related to the problem of interest (Streubert & Carpenter, 2011:28,90; Creswell, 2012:206). The selection of participants is guided by the inclusion criteria whereby particular individuals are selected. This is done based on the knowledge and experience to provide the required information for the study (Botma *et al*., 2010:201; Polit & Beck, 2012:279; Brink *et al*., 2012:141).

Registered nurses, who met the stipulated inclusion criteria, were selected by the researcher to participate in the study. RNs were purposefully chosen to supply the necessary information related to the research problem due to their experience working in a care-and-rehabilitation facility. The selection of the population was suitable, because the RNs had experience on the topic explored in the study.

2.9 Inclusion criteria

Inclusion criteria will determine which individuals of the population will be included in the unit of analysis. Inclusion criteria refer to the criteria that specify population characteristics (Polit & Beck, 2012:274).

2.9.1 Inclusion criteria were:

- Registered nurses, with or without psychiatric qualifications, working in the care-and-rehabilitation facility at the Free State Psychiatric Complex;
- Registered with the South African Nursing Council;
- Males and females;
- Work experience in terms of PWID's for more than 3months, and;
- Willing to participate and written consent given.

2.9.2 Exclusion criteria

Area managers were excluded from participating in the study, because they form part of the top management. The researcher conducted an explorative interview before the main study to indicate whether the research question and technique would be effective.

2.10 Explorative interview

An explorative interview is described as a small study with 5-12 participants that the researcher conduct before the first study to test the feasibility of the data collection method as well as the clarity of the research question (Polit & Beck, 2008:13; Green & Thorogood, 2009:57). The researcher conducted an explorative interview a month before the first NGD meeting to test the participants' understanding of the research question and the selected study technique. Five RN's, who gave informed consent, were invited individually to meet in a boardroom within the institution at a specific time. The arrangements were made with the permission of the area manager. The research question asked was: "What do you recommend to enhance the therapeutic role of the registered nurses in a care-and-rehabilitation facility?" The research question and a short description of the therapeutic role were available as a point of reference for the participants.

The researcher followed the first three steps of the NGT to test the research question. The research technique process was explained to the participants by the researcher. The research question was presented, and the researcher gave the participants time to think about the question. All the participants wrote their ideas, as response to the

research question, on the paper provided. Each participant was offered the opportunity to clarify ideas and thereafter the discussion took place. Data collected was not included as part of the study results, because the researcher did not conduct all the NGT steps. The research question remained the same for the actual study, because it was clear and understood by the participants. Some of these RN's also participated in the NGD meetings, conducted afterwards.

2.11 Data collection process

The researcher organised NGD facilitated by an experienced person. The data was collected after the University of Free State Health Science Research Ethics Committee, the Free State Department of Health (FSDoH) and the hospital management approved the study to be conducted (Annexure D).

The four NGD meetings took place over a three month's period, from October to December 2018 between 10:00-12:30 and 13:00-15:30. Wednesdays were appropriate because there was a changeover between nurses' shifts. This overlapping of shifts occurred over two hours, ensuring that each ward had an extra RN caring for the patients while the second RN could attend the NGD. Each group took about 2-2½ hours until no new ideas were generated. Thus, enough time was available to conduct the NGD's, together with patient care prioritised. After the four NGD's were conducted, data saturation was reached. Data saturation occurs when there is no new additional information expressed by the participants (Brink *et al*., 2012:141; Polit & Beck, 2012:521). The participants started to repeat similar information, confirming that a point of data saturation was reached. The facilitator notified the researcher after every completion of a NGD meeting. The total number of participants in all four NGD's was 22. Four NGD's comprised between 4-8 members per group. The specific numbers for each NGD was 8, 5, 5 and 4 participants respectively. See table 2.1. below.

Table 2.1 NGD groups and number of participants

Group 1	Group 2	Group 3	Group 4	Total
8	5	5	4	22

2.11.1 Sampling of participants

Recruitment of the participants took place on a specific Wednesday in a meeting held by the area manager (gatekeeper) with the registered nurses when both shifts of RN's were present. With permission from the area managers, the researcher presented information about the study. After that, invitation letters were distributed to the RN's during the meeting. All those interested in participating, received consent forms (Annexure C) for their perusal. Signed consent forms were collected after the meeting by the researcher. Staff members that did not attend the meeting were contacted individually to give them a chance to participate. RN's were contacted individually thereafter to make appointments on specific dates, time and venue as agreed upon with the facilitator. The researcher grouped participants into four NGD's on different dates. The participants were grouped based on their availability for a specific date to attend a NGD. Text messages were sent by the researcher three days ahead of the scheduled time to remind those participants who gave informed consent, to participate in NGD's.

2.11.2 Preparation for the NGT

The NGT is a structured four step approach that requires preparation. The researcher prepares the room and supplies to be used during the meeting (Delbecq *et al*., 1975; Rice *et al*., 2018:1-9). The meeting room was free from distractions and spacious enough to seat 5-12 people. The tables were arranged in a U shape, with a flip-chart placed at the open end of U. Each participant was provided with pens, pencils, voting cards, papers and five voting cards (Delbecq *et al*., 1975; Dang, 2015:14-25).

The researcher arranged the venue, date and time with the area manager's permission. A boardroom, conveniently situated within the institution, was booked for each NGD. It was spacious to accommodate three big tables and eight chairs. The chairs were arranged in a U-shape for the participants to remain seated during the NGD meetings. The facilitator was standing in front of the flip-chart, which was positioned against the wall. See figure 2.1 below, showing the U-shape composition for the NGD meetings. Stationery provided for each participant comprised of 5 voting cards, pencils, an eraser, colour pens, two papers with the research question and a short description of the

therapeutic role of registered nurses. Refreshments, such as bottled water and sweets, were available for the participants. They also received some finger snacks after the termination of the NGD meetings as a token of appreciation.

The researcher covered the boardroom glass door and windows with curtains to ensure privacy. Furthermore, “do not disturb” signs were placed on the corridor walls and also on the boardroom door.

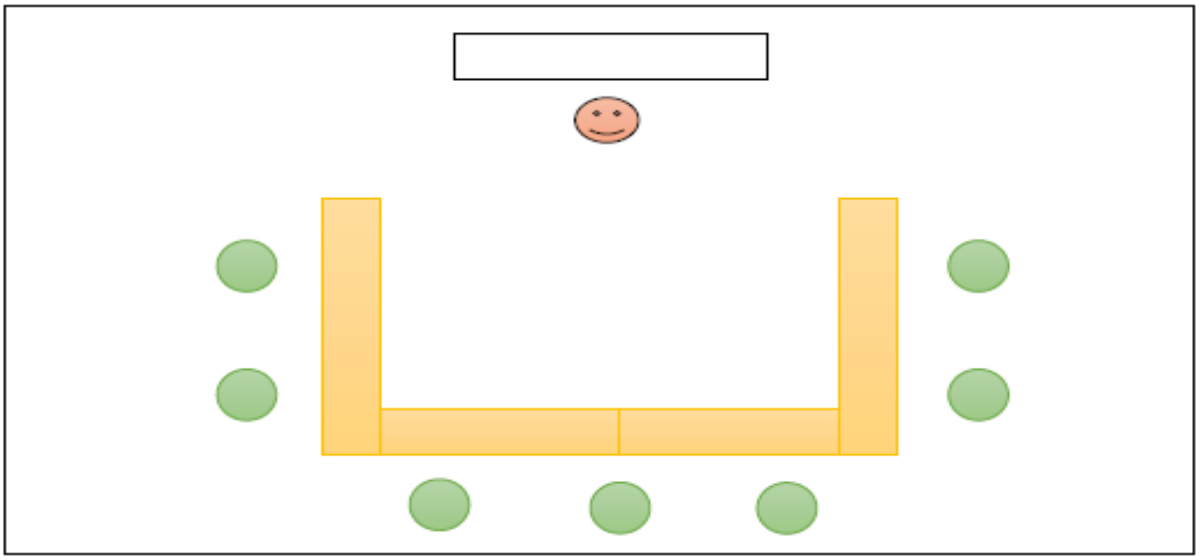

Figure 2.1 U-shape composition for the NGD meetings

2.11.3 Conducting nominal group discussions according to the nominal group technique

The NGT is a facilitated process. Therefore the facilitator, who conducts NGDs, needs to make an opening statement. The opening statement should include :

- A warm welcome to all the participants;
- Introduction of the role of each participant and a statement on the importance of each group member’s contribution;
- Guidelines on the NGT process, pitched on the level of the group members for them to understand, and

- Indication how the group outcome will be used (Dang, 2015:14-25; Rice *et al*., 2018:1-9; U.S. Department of Health, 2018).

The facilitator welcomed the group members and explained the purpose and objective of the meeting. The group members' roles and the value of their contributions were clarified. The facilitator gave the participants a brief description of NGT procedural steps to be followed and how the group output would be used. As mentioned, the NGT is a structured four stage approach (Delbecq *et al*., 1975; Dang, 2015:14-25; McMillian *et al*., 2016). The facilitator followed four NGT stages that are briefly explained below.

2.11.3.1 Stage 1: Generating ideas (10-15 minutes)

The facilitator presented the following research question: "what do you recommend to enhance the therapeutic role of registered nurses in a care-and-rehabilitation facility?" Each participant received a paper copy of the research question. Each participant was requested to generate ideas individually, silently and to write them down (Delbecq *et al*., 1975; Lennon *et al*., 2012). The facilitator explained to the participants that they had to write a list of ideas silently and independently on the papers provided. It was also indicated that the ideas were to be presented in the second stage round-robin.

2.11.3.2 Stage 2: Recording and sharing of ideas - round-robin (30minutes)

A round-robin approach gives one participant time to share a single idea with the group while they are listening. There is no discussion on the expressed ideas and ideas are only recorded on the flip-chart (Lennon *et al*., 2012; McMillian *et al*., 2016; Rice *et al*., 2018:1-9). The facilitator asked each participant to verbalise an idea on how to enhance their therapeutic role in a care-and-rehabilitation facility. The facilitator wrote each idea on the flip-chart visible to everyone. Each participant contributed one idea at a time in a round-robin manner until all ideas were listed. This process continued until data saturation was achieved. Participants allowed in stage 3 to discuss and debate ideas during a group discussion.

2.11.3.3 Stage 3: Group discussion (30-45 minutes)

During this stage, all ideas were discussed to ensure the participants' understanding of each statement. The participants were well informed to vote for the ideas at a later stage

(McMillian *et al*., 2016). The facilitator read the multiple ideas loudly from the flip-chart. The participants clarified each idea and they discussed the meaning of vague ideas. The participants' ideas were grouped and categorized into themes (Lennon *et al*., 2012; Dang, 2015:14-25). The constructed ideas with similar meaning were grouped into various themes during NGD's by the facilitator and the group members. Suggestions were fine-tuned, and appropriate ideas were written on the flip-chart after the group agreed upon it. This process assisted the facilitator to make sense of the complexity of ideas. No judgment of ideas occurred from any participant, and everyone was satisfied with the meaning of each idea. In stage four of the NGT participants prioritised ideas in order of importance.

2.11.3.4 Stage 4: Voting and ranking ideas

Each participant received five voting cards. The participants selected the five most important ideas individually from the group list on the flip-chart without any discussion with other group members. Thereafter one idea was written per card. The facilitator specified that a number should be allocated to each selected idea on each voting card. Thereafter the five ideas had to be ranked from 1-5**.** The participants were requested to award 5 points to the most important idea, 4 to the second and then 3, 2, and 1 on each card**.** The points awarded for each idea were presented to the participants in a group. The process continued by reading the idea numbers, the points awarded and then the facilitator wrote it on the flip-chart (Delbecq *et al*., 1975; McMillian *et al*., 2016).

In this study, each participant received five numbered cards from the facilitator and instructions to view the final list of ideas. After that, they were asked to prioritise each idea from the list in private on their five cards. Card number 5 indicated the idea that was the most important to them, whereas card 1 showed the least important idea. After participants completed their prioritisation, they were requested to display their cards. This was only visible to the facilitator. The facilitator then recorded each participant's idea, number and score onto the flip-charts. Everyone could see the final results on the flip-chart. All the voting cards were collected from the participants after completion of the process. They were used for data analysis by the researcher thereafter. Table 2.2 shows an example of the flip-chart with scores.

Table 2.2 Example of flip chart scores

Numbering	Idea/statement	Score allocated	Final score
1	Skills and development	4+5+5+4	18
2.	Safety, clean environment and equipment	5+2+4+5	16

2.12 Data analysis

Data analysis is a process whereby the researchers organise and interpret raw data collected, to find meaning (Polit & Beck, 2012:556; Patton, 2015:521). The collected data was organised into themes and categories to interpret and facilitate the comparison of data sets (Creswell, 2009:183,185). According to Van Breda (2005:3), the NGT uses both qualitative and quantitative data analysis techniques to consolidate participants' statements. The participants' statements from the four NGD's were combined and classified into themes by the researcher by means of five steps. These steps must not be confused with those of the NGT. These data analysis steps assist to manage the data. All four NGDs' statements were combined and classified into themes by following the first four steps prescribed by Van Breda. In step 5, the important themes were prioritised according to specific calculations proposed by Van Breda. Step 6 is optional and consists of demographic information. Step 7 implicates reporting on the data analysis (Van Breda, 2005:4-11).

2.12.1 Steps followed in analyzing multiple group, nominal group data by Van Breda (2005:4):

Step 1: capture data on a computer

Step: 2 identify the top five

Step: 3 content analysis of data

Step: 4 confirm the content analysis

Step: 5 calculating combined ranks

Step: 6 comparing demographic data groups (optional)

Step: 7 reports the NGT data

2.12.2 Step 1: Capture data on a computer

The researcher typed data collected on a spreadsheet developed on the computer for the four NGD's. The nominal group statements were typed, with the individual and group scores allocated for each statement. A table was inserted in the Word document. This table was divided into six columns and labelled A, B, C, D, E and F. Thereafter, the researcher typed specific information accordingly in the relevant columns, namely:

Column A - *group*

Column B - *statement*

Column C - *theme*

Column D - *scores*

Column E - *average*

Column F - *Top5*

For an example of the nominal group technique spreadsheet for group 1, see table 2.3 below:

Table 2.3 Nominal Group Spreadsheet: Group 1

GROUP 1 N=8 (A)	THEME (B)	STATEMENT (C)	SCORES (D)	T0TAL SCORE / MEMBERS = AVERAGE (E)	TOP5 (F)
1		1.Institutional policies and procedures	4,5,4,1	14/8 = 1.75	
1		2.Rehabilitation	5,2,4,5	16/8 =2	

Each nominal group's data was recorded on its spreadsheet by the researcher. Column A indicated the group number (for example Group 1 and the number of group members n=8). Column C is the list of group statements as it appeared on the flip-chart, and Column D (scores) consisted of individual scores for each statement (for example 4, 5, 4, 1 or 5, 2, 4, 5) respectively. Column E (average score) was calculated by dividing the total score of each statement with the number of group members in each group. For example, scores (4+5+4+1=14) divided by number of members (group1 = 8 members) produces an average (14/8=1.75). Column B (theme) and Column F (top5) were left blank to be completed later in the steps to follow. The same process was repeated for the remaining three groups 2, 3 and 4.

2.12.3 Step 2: Identifying the top five

The participants' statements were ordered according to how important the group felt the statement was. In all four NGD groups, members prioritised the five important statements. Column E (average score) data was arranged in descending order from the highest to the lowest number for each group. From these data, the top 5 statements were identified with an X in column F. Some statements shared the same priority ranking according to how important the participants perceived the statement to be. Refer to Table 2:4(a), identifying the Top 5, see an example of group1 below. (See Annexure E for the Top 5 of group 2, 3 and 4).

Table 2.4(a) Identifying Top 5 for Group 1

GROUP 1 N=8 A	THEME B	STATEMENT C	SCORES D	T0TAL SCORE / AVERAGE E	PRIORITY	TOP 5 F
1		1.Institutional policies and procedures	4,5,4,1	14/8=1,75	3	X
1		2.Rehabilitation	5,2,4,5	16/8=2	2	X
1		4.Enhance communication	1,3,1,4,1,2	12 /8= 1.5	4	X
1		6. Management support	1,3,1,4,1,2	12/8 =1.5	4	X
1		8.Treatment	5,5	10/8 = 1.25	5	X
1		9. Focus on activities of daily living improvement	5,2,4,5	16/8=2	2	X
1		15.Skills development	4,5,5,4	18/8 = 2.25	1	X
1		20.Support systems	1,3,1,4,1,2	12/8 = 1.5	4	X
1		24.Privacy and confidentiality	5,5	10/8 = 1.25	5	X

Table 2.4(b) Column (E) in descending order top 5 (Group1) with an X Column (F)

GROUP 1 N=8 A	THEME B	STATEMENT C	SCORES D	T0TAL SCORE & AVERAGE E	PRIORITY F	TOP5 G
1		1.Skills development	4,5,5,4	18/8 = 2.25	1	X
1		2.Rehabilitation	5,2,4,5	16/8 = 2	2	X
1		3. Focus on activities of daily living improvement	5,2,4,5	16/8 = 2	2	X
1		4.Institutional policies and procedures	4,5,4,1	14/8 = 1.75	3	X
1		5.Enhance communication	1,3,1,4,1,2	12/8 = 1.5	4	X
1		6. Management support	1,3,1,4,1,2	12/8 =1.5	4	X
1		7.Support systems	1,3,1,4,1,2	12/8 = 1.5	4	X
1		8.Treatment	5,5	10/8 = 1.25	5	X
1		9.Mental Health Act	5,5	10 /8 = 1.25	5	X
1		10.Privacy and confidentiality	5,5	10/8 = 1.25	5	X

All the statements that participants felt were very important in the four NGD's appeared in the Top 5 statements. Statements marked with (X) were Top 5 statements from each NGD according to the importance to the group (refer to Annexure E). In a similar way the Top 5 statements were identified for all four NGD's. The total score column indicates how many times the participants mentioned the theme. The more group members referred to the theme, the higher the chance became for prominence, even if these

statements received the lowest votes. The average score column shows the sum of all statements, organised in descending order from the highest to the lowest number. The final ranking column is the sum of three columns (C, E and G). The final ranking shows concludes the whole picture of consolidated statements as they were generated and ranked by the participants (Van Breda, 2005:10). Legislative and policy framework received the highest score amongst the top five statements (n=9) and communication had the lowest score of the top five statements. See table 2.5 for the scores of the Top 5 statements in each theme.

Table 2.5 Top5(x) Statements in each theme

Themes	Statements
1.Legislative and policy framework	**9**
2.Resources	**8**
3.Education	**7**
4.Care delivery	**6**
5.Healthcare environment	**1**
6.Staff Support	**5**
7.Commmunication	**2**
Total	**38**

2.12.4 Step 3: content analysis of data

In this step, the group members' statements are categorized into themes or categories (Van Breda, 2005:5). The facilitator and the participants already grouped the statements with the same meaning during NGD's. The researcher read through the list

of all four NGD meetings' statements. The statements were perused several times to better understand the mentioned ideas and identify the theme that emerges from each statement. The researcher compiled a list of numbered themes, as separately identified. The list of themes represents the participants' ideas towards the research question posed to them. Each statement was categorised under one theme (Van Breda, 2005:6). The statements were revisited by the researcher to confirm in which theme, each statement belongs. The researcher rechecked that each statement was only allocated to one theme only. From the main themes, sub-themes emerged, and the researcher compiled a list of themes with sub-themes.

The researcher requested colleagues with experience of working with PWID's and research to assist with the process to verify themes. The researcher explained the study briefly and presented the research question to the colleagues. A printed copy of the NGD's statements and themes was supplied to these colleagues. All the results were presented, discussed and an agreement was reached between colleagues. A printed copy of themes and sub-themes was sent to the study supervisor for rechecking. The researcher discussed the themes and sub-themes that emerged with the study supervisor until an agreement was reached.

The main themes were entered in column B (Themes), and a sub-themes column was created for easy interpretation of the data at a later stage. Statements that did not receive votes were not discarded. The researcher followed up on these statements to understand the intent of the participants**.** See Table 2.6 for examples of themes and sub-themes.

Table 2.6 Themes and sub-themes

THEMES	SUB-THEMES
1. Legislative and policy framework	**1.1** Batho Pele Principles **1.2** Patient Rights **1.3** Policy and procedures

2.Resources	**2.1** Physical resources **2.2** Human resources

The created themes and sub-themes needed to be verified by different raters before the researcher could finalise this process. The researcher requested assistance from colleagues to confirm the accuracy of the content analysis process.

2.12.5 Step 4: confirm the content analysis

The researcher printed a copy of all four NGD's statements, together with a list of themes and sub-themes. The researcher selected an additional small group of five RN's who were not part of the NGD's. They were given a summary of the study background and research question, together with copies of all four NGD's statements and a summarized list of themes. The RN's were requested to work independently to indicate the matches between the participant statements and the identified themes. Thereafter, the researcher compared the RN's results with her own to identify the similarities and differences.

These comparative results were discussed with the study supervisor. The supervisor received copies of the suggested themes and sub-themes, as well as those from two independent researchers. They checked and verified the themes and sub-themes from the NGD's statements. This was then again presented to the study supervisor. Thereafter the themes and sub-themes were finalised.

2.12.6 Step 5: calculating combined ranks

The researcher followed sub-steps to determine the relative importance of the combined NGD's data. The researcher sorted data within the columns in ascending and descending order. The second spreadsheet was created by the researcher with eight columns A, B, C, D, E, F, G and H. To enable the researcher to calculate the top 5 themes, average and final rank scores of nominal groups were used (Van Breda, 2005:7). A theme list for the four NGD's was consolidated and prioritised. The themes were ranked from 5 to 1 in order of priority in column C, E and G. The theme that appeared on top of the list was rated five as the first choice, second choice was given a

four, third choice equaled a three, fourth choice received a two and the fifth choice was allocated a one. This was given based on all four groups combined. Column C, E and G's ranks were added together, and their sum entered in column H. Column H (final ranking order) was arranged in descending order. Column H provides consolidated and ranked statements of the four NGD's. A copy of the researcher's calculations to determine the ranking order was sent to the study supervisor and two expert researchers to be verified for accuracy. See table 2.7 for the calculated combined ranks of NGT data.

Table 2.7 Calculated combined ranks

A THEMES	B TOP5 (1)	C TOP5 (2)	D NUMBER (1)	E NUMBER (2)	F AVERAGE (1)	G AVERAGE (2)	H FINAL RANK= C+F+G
1.Communication	2	6	2	6	2.9/2=1.45	6	18**(1)**
2.Staff support	5	5	5	5	8.4/5=1.68	5	15**(2)**
3.Healthcare environment	1	7	1	7	5/1=5	1	15**(2)**
4. Care delivery	6	4	6	4	14.8/5=2.46	2	10**(3)**
5. Education	7	3	7	3	12.55/7=1.79	4	9**(4)**
6. Legislative and policy framework	9	2	9	2	13.05/9=1.45	6	9**(4)**
7. Resources	8	1	8	1	14.05/8=1.75	4	7**(5)**

The final ranking showed that communication received the highest score and was ranked first. The second theme, staff support and healthcare environment shared the

2nd rank followed by care delivery in the third position. Education, legislative and policy framework apportioned the fourth position, which left resources in the fifth position.

2.13 Trustworthiness

Trustworthiness describes the researcher's intention to maintain the quality of the research and substantiates that the findings reflect the truth. It is the degree of confidence in data, interpretation and methods used. This ensures the quality of a study. The researcher established that the study findings are credible, dependable, confirmable and transferable (Lincoln & Guba in Polit & Beck, 2012:584-585). The researcher adhered to the criteria outlined by Lincoln & Guba (1985) to establish trustworthiness in the study. These criteria include credibility, dependability, confirmability and transferability.

2.13.1 Credibility

Credibility refers to the confidence in the truth and interpretation of the data. It ensures the believability for the reader (De Vos *et al*., 2011:419; Brink *et al*., 2012:172; Polit & Beck, 2012:584-485). Each step of the research process was explained to the readers to enable them to understand how data was collected and analysed. The researcher used an experienced facilitator to conduct NGD's to minimise bias during data collection. The selected participants were RN's working in a care-and-rehabilitation facility who had to provide the appropriate information in the study. The participants generated the ideas. These notions were recorded in their presence and by means of a flip-chart by the facilitator. Each participant received an equal chance for their voices to be heard. Data collected on the flip-chart was clarified, verified and confirmed by the participants during NGD's until consensus was reached.

Credibility involves strategies such as peer debriefing and member checking (De Vos *et al*., 2011:420). Peer debriefing is a used to seek opinions of experts who were not part of the study. Credibility was enhanced in the study by conducting peer debriefing. The opinions of expert researchers, not involved with the study during data analysis, were persued. The peer debriefing session was conducted to address arising questions on the phenomenon studied (Brink *et al*., 2012:172; Polit & Beck, 2012:594). Registered

nurses with expertise were requested by the researcher to recheck and confirm themes identified in the process. Dependability was also established by the researcher to ensure that the findings of the study were consistent.

2.13.2 Dependability

Dependability refers to the stability of the research data over time. The findings will be the same or similar if the same study is repeated with participants that are alike in the same type of setting. It involves the evaluation of the quality of data collection, data analysis, findings and recommendations. These were tested against the data received from the participants (Polit & Beck, 2012:585). The researcher had to establish that the data collected was the participants' viewpoints. The data collected during the NGDs was written on the flip-charts by the facilitator. The researcher transferred data collected, as it appeared on the flip-charts, to the computer. It reflected the participants' voices. The research process and NGT followed, was also described in detail by the researcher. This offered the reader information to understand the methods used in the study. This detailed description of the current research may awake a dependable repetition of the process.

2.13.3 Confirmability

Confirmability refers to the objectivity and accuracy of the data. It shows whether data presented by the researcher is a true reflection of the information provided by the participants (Streubert & Carpenter, 2011:49; Brink *et al*., 2012:173). The researcher rechecked data collected on the flip-charts for all four NGD's for confirmation. The participants verified data on the flip-chart during the NGD's, together with the facilitator, to reach consensus. The study supervisor also rechecked the accuracy of data captured from the flip-chart to the computer. The researcher utilised independent researchers to conduct an enquiry audit. Two independent researchers were involved in rechecking the themes created by the researcher from the participants' statements. This strengthened the confirmability of the current research.

2.13.4 Transferability

Transferability is the extent to which the researcher findings can be applied, or have meaning, to others in a similar situation (Botma *et al*., 2010:233; Streubert & Carpenter, 2011:49; Brink *et al*., 2012:173). The strategies to enhance transferability include a extensive description, purposive sampling and data saturation (Brink *et al*., 2012:173). A detailed description of the NGT steps was given to collect data. Data analysis and the research process were documented by the researcher. The purpose of the study was to explore and describe the recommendations of registered nurses to enhance their therapeutic role in a care-and-rehabilitation facility. The participants with knowledge and experience with regard to the study problem were selected purposefully to obtain information. The data collection process continued until saturation was reached. Therefore, the reader was empowered to make a judgment whether the research findings can be transferred.

Although the researcher aimed to ensure trustworthiness by means of the four criteria, it was also necessary to be mindful of ethical considerations (Polit & Beck, 2012:150).

2.14 Ethical considerations

Ethical considerations are principles that need to be followed by the researcher to guide research with human participants. Ethical principles direct the researcher on how to conduct the research and aim to protect human rights. The standards of ethical conduct in research are based on the principles of beneficence, respect for human dignity and justice. These are mentioned in the Belmont report (Brink *et al*., 2012:34; Polit & Beck, 2012:152). The researcher applied for approval and permission to execute the study before the commencement of the study.

2.14.1 Ethical approval and permission to access participants

The researcher had to obtain permission from the relevant authorities in writing before the research could be conducted. Ethical approval and permission to conduct a study were granted from the different authorities, namely the Research Ethics Committee, the Department of Health and the facility where the study was conducted (Botma *et al*., 2010:11-12). The research proposal was submitted to the School of Nursing

Evaluation's Committee, and thereafter the Health Science Research Ethics Committee (HRSEC) of the University of Free State. Permission was granted to conduct the study. Thereafter an application was submitted to the Free State Department of Health, after approval from the University of Free State. Permission was also granted by the hospital management before the research was conducted to access the registered nurses and the wards. (See Annexures A and D for the application and permission letters)**.**

The researcher had an ethical obligation to conduct research according to ethical standards (Polit & Beck, 2012:152). All participants involved during the research process adhered to the ethical principles. These principles are now discussed briefly.

2.14.2 Respect of human dignity

Respect for human dignity includes the right to self-determination and to make an informed decision to participate in the study (Polit & Beck, 2012:154). The participants were informed comprehensively about the research whereafter the facilitator obtained permissionfrom them. The consent form discussed with participants in this study disclosed the aforementioned information to the participants.

2.14.3 The right to self determination

The researcher respected the participant's right to participate, or not participate, in the study. It includes the right to withdraw from participating (Polit & Beck, 2008:171; Brink *et al*., 2012:34-35; Polit & Beck, 2012:154). The participants participated voluntarily and freely in the study. They were not forced by the researcher. The participants were made aware of their right to withdraw from participating at any stage of the study. This was also stated in the consent form.

2.14.4 Informed consent

Informed consent involves the full disclosure of information to participants related to the research. It acknowledges the participants' understanding of the risks and benefits involved. The participants' rights are explained, such as the right to withdraw from participating in the study (Brink *et al*., 2012:38-39; Polit & Beck, 2012:157-159; Babbie, 2013:34). Voluntary participation of the registered nurses was based on the information

received about the study, for them to make an informed decision. Both the researcher and facilitator explained the study, the risks and benefits involved, together with the right to withdraw from participating at any stage in the study without penalty. An information brochure with the contact details of the researcher was given to the participants. All the participants signed informed consent forms prior to the NGD's. See Annexure C as example of a consent form. Furthermore, the researcher adhered to the principle of beneficence. This ensured that the wellbeing of the participants was protected.

2.14.5 Beneficence

It is the researcher responsibility to minimise any harm and discomfort to the participants. It needs to be prevented that the participants experience physical, psychological, emotional, spiritual, economic, social or legal harm and discomfort (Babbie, 2013:34-35; Brink *et al*., 2012:35; Polit & Beck, 2012:152). The researcher protected the participants' information provided and their identity**.** No identifying information appeared on any documents or could be linked to any participant.

2.14.6 Confidentiality

Information gathered from the participants was kept safe to prevent access by others not involved in the study. Participants were assured that their identity was protected and their names could not be linked to the information provided (Babbie, 2013:35; Brink *et al*., 2012:38; Polit & Beck, 2012:162-163). NGD information, received from the participants, was kept confidential. No names of the participants were mentioned. The data collected, was locked by the researcher and only accessible to the researcher and the study supervisor. A discussion of the principle of justice follows.

2.14.7 Justice

Justice is an ethical principle that includes proper selection and treatment of the participants by the researcher (Brink *et al*., 2012:36; Polit & Beck, 2012:155). Registered nurses working in a care-and-rehabilitation facility were called for a meeting by the area manager. Here, the information about the study and invitation letters was

given. The study information was explained, and contact details were issued to the RNs. Those RNs who were not present in the meeting, were contacted individually by the researcher to give them a chance to also participate. The selection of the RNs was based on the inclusion criteria, whereby those who met the inclusion criteria were allowed to participate in the study. There was no RN's, who met the inclusion criteria, who were treated unfairly in the selection process.

2.15 Conclusion

Chapter 2 aimed to describe the research design, methodology, research technique, data collection, data analysis, trustworthiness and ethical considerations. The study findings and discussion thereof will be the focus of chapter 3.

CHAPTER 3

Description of research findings and literature control

3.1 Introduction

In this chapter, the discussion will concentrate on the demographic data and research findings from all four NGD's. This chapter presents the demographic data, an overview of research findings and themes, as well as sub-themes constructed from the NGD's. It links to the descriptions in chapter 2. The purpose of this study was to explore and describe the recommendations of registered nurses to enhance their therapeutic role in a care-and-rehabilitation facility. The discussion of the NGD's findings was according to the priority of the themes that were divided into sub-themes. The findings were illustrated through verbatim statements abstracted from NGD transcripts.

3.2 Demographic data of participants

Classification of the participants' demographic data in the four nominal group discussions (NGD's) was according to the criteria of qualifications, race, gender, age and work experience. The researcher collected the participants' demographic information before each group discussion. Refer to table 3.1 for the demographic profile of the participants in all four NGD's.

Table 3.1 Participants demographic profile

	GROUP :1 N:8	GROUP :2 N:5	GROUP:3 N:5	GROUP:4 N:4
Qualifications With psychiatry nursing	**7**	**5**	**4**	**3**
Without Psychiatry nursing	**1**	**0**	**1**	**1**
Race Black	**3**	**5**	**4**	**4**
White	**3**	**0**	**1**	**0**
Coloured	**2**	**0**	**0**	**0**
Gender Females	**7**	**1**	**2**	**1**
Males	**1**	**4**	**3**	**3**
Age 20 -34 Years	**4**	**2**	**2**	**2**
35-60 Years	**4**	**3**	**3**	**2**
Work experience < 1 Year	**5**	**1**	**2**	**1**
> 1 year	**3**	**4**	**3**	**3**

The total number of registered nurses that participated in the study was 22, representing four groups. These groups consisted the following number of participants: the first group was compiled by eight participants (n=8) of which seven were female and one male, group 2 and group 3 both had five participants (n=5) each and the fourth group only four

registered nurses participated (n=4) in the NGD's. The last three groups, the second, third, and fourth group, comprised of more females compared to the first group. The first group had the highest number of participants (n=8) as compared to other NGD's. The fourth group had the lowest number, with only four participants (n=4).

The majority of the participants (n=19) in the four NGD's had a psychiatric nursing qualification, and only three were without a psychiatric nursing qualification. Thirteen RN's (n=13) had work experience of more than a year, compared to nine RN's (n= 9) with work experience of less than a year. The study represented an equal number of 11 (n=11) male and female participants distributed over the four groups. Participants data, related to race, comprised of 16 Black, 4 White and 2 Coloured participants. The participants' ages ranged from 20-34 years (n=10) and 35-60 years (n=12).

3.3 Comparison of the nominal group discussion statements

The participants in the four NGDs generated a total number of 66 statements. The first group, which was the largest group of eight (8) participants, generated 24 statements. Group two with five participants compiled nineteen (19) statements, while group three with five participants' created only seven (7) statements. The fourth group, with the lowest number of participants, namely four (4) produced 16 statements. Van Breda (2005:3) stated that larger groups usually generate more statements than smaller groups. Table 3.2 below shows the number of participants and all the statements per NGD.

Table 3:2 Participants and statements per NGD

Group	Participants	Statements
1	**8**	**24**
2	**5**	**19**
3	**5**	**7**
4	**4**	**16**

Total	**22**	**66**

Group 1 had a high number of female participants (n=7) that generated 24 statements compared to the nineteen (n=19) statements of group two consisting of more males (n=4). Top 5 scores include all the statements that the participants regarded as important in the groups. The possibility exists that a group may generate a number of statements, but only a few statements are selected by voting as very important by the participants; to eventually appear in the top five (Van Breda, 2005:10). From twenty-four (n=24) statements of group 1, only ten (n=10) statements appeared in the top five as compared to group 3 with all seven (n=7) statements in the top five. An interesting observation was that all the statements of group 3, with more male participants (N=3), received a lion's share of votes indicating the importance thereof. It also depends on how often the groups refer to the theme that influence its importance (Van Breda, 2005:10). The sixth theme received more of the top five statements (n=9) in the four NGD's combined, compared to the first theme with the lowest number of the top five statements (n=2).

The consolidated and prioritised seven (7) themes and eighteen (15) sub-themes, from 66 statements generated in all four NGD's, were:

- Communication
- Staff support
- Healthcare environment
- Care delivery
- Education
- Legislative and Policy framework
- Resources

Table 3.3 below shows the themes and sub-themes that emerged.

Table 3.3 Themes and sub-themes

THEMES	SUB–THEMES
Communication	Vertical and horizontal communication Interpersonal relationships
Staff support	Multidisciplinary approach Management support
Healthcare environment	
Care delivery	Community and family involvement Rehabilitation Stimulation program and activities of daily living
Education	Orientation and induction Mentorship Skills training
Legislative and policy Framework	Batho Pele principles Patient's Rights Policy and Procedures
Resources	Physical Resources Human Resources

According to Van Breda (2005:10), the most important theme is the one at the top of the theme list when all the groups are combined. The least important is considered at the bottom. Communication received the highest votes of n=18 in the first ranking position. The second position of staff support received n=15 votes. This rank is shared with the healthcare environment and the third position was care delivery. The fourth position was split by two themes, namely education, legislative and policy framework,

followed by the fifth theme resources. The researcher discusses these themes and sub-themes according to the sequence displayed in table 3.3, together with the unedited quotes from participants.

3.4 Communication

Communication is a process whereby information is transmitted from a sender to a receiver. It is two-way interaction occurring between at least two people (Roussel & Swansburg, 2009:150-154). Messages are sent to one another, accompanied by attached meaning (Smit *et al*., 2016:411). In a health care setting communication is a pre-requisite to build a relationship between nurses, patients and other health care professionals (Cullen & Gordon, 2014:23-29)**.** Communication between RN's and managers is necessary to deliver efficient and coordinated care for PWID's, as specified by the participants. According to the participants, communication should be:

> ***"Clear precise and proper from top to bottom vice versa to share information."***

This statement supported the importance of communication between management and the RN's. Nursing managers should communicate the necessary information to the nurses to perform their tasks. However, lack of communication leads to poor health care delivery and have a negative impact on nurses' performance and conduct (Cullen & Gordon, 2014:23-29; Wagner *et al*., 2015:974-982). Well-informed nurses will have an understanding of nursing care in a care-and-rehabilitation facility and a positive attitude to deliver better and compassionate patient care. Regular feedback and updates of information may contribute to improved therapeutic care nursing practices (Bloemfield & Pegram, 2015:45-50; Wagner *et al*., 2015:974-982). Open communication between managers and the RN's may develop mutual trust and build relationships, minimising conflict situations (Pagano, 2014:249). Trust between management and RN's could develop through transparent communication, indicated by the following statement:

> ***"Transparency in communication builds trusting relationships."***

Communication works both ways and benefits all parties involved. Nurses need to communicate with the patients during service delivery to build nurse-patient

relationships. Stephen (2011:808-813) highlighted that nurses could also benefit from effective communication to develop a compassionate relationship with the patients. Ineffective communication between the nurse and patient may influence the therapeutic relationship. Subsequently, it may increase nurses' job stress and burnout. Compassion is fundamental to patient-centred care, contributing to therapeutic nursing care (Babaei *et al*., 2017:91-96). Participants reasoned that better communication might improve therapeutic care:

"Show love to the patients and treat them like human beings."

According to Roussel and Swansburg (2009:150-154), the the various areas of communication systems need to be assessed for effectiveness. They are accessibility of information, communication channels, clarity of information, flow control and individual communication. The participants felt that if nursing managers use proper communication channels, it will ensure access and clearly communicated information to all nursing categories.

"Enhance communication to be clear."

"Quick communication will increase access to verbal and written information."

It seems as if effective and clear communication may assist RN's to be better informed, influencing their nursing practices. Effective communication increases employees job commitment and satisfaction. Some benefits associated with effective communication include high job satisfaction, strong decision-making ability and working relationships (Sankaranarayanan & Sindhu, 2012:148). Communication between managers and nurses, colleagues, nurses and patients generate a positive work climate. Nurses become committed and self-motivated to perform their duties (Vermeir *et al*., 2018:21-27). Sub-themes discussed under this category of communication are vertical and horizontal communication and interpersonal relationships.

3.4.1 Vertical and horizontal communication

Formal communication in health care systems flow in various directions, including vertical and horizontal. Vertical flow means receiving and sending messages upwards

and downwards in a hierarchy. Top managers will know about the lower-level workers' problems if there is communication. At the same time, workers get the opportunity to suggest the necessary improvements and their feelings regarding the institution to top management (Bergman *et al*., 2016:533-541). Participants highlighted a need for better communication flow, by saying:

> **"*Communication should be from management to nurses, from nurses to management relating information to different levels."***

It is, therefore, quite understandable that RN's become demotivated by unproductive management communication patterns. However, Gordon, Deland and Kelly (2015:23-27) argued that managers' report that the lack of time contribute to poor communication with their subordinates. In this study, the participants felt that management have the responsibility to arrange communication meetings with staff to transfer relevant information. They expressed it as follows:

> **"*Contact meeting with visible managers."***

One way of disseminating information is to have regular meetings. Such meetings can provide updated information and solutions to problems experienced by staff. Meetings could include discussions on patients' needs, share information and plan the way forward (Wagner *et al*., 2015:974-982). Furthermore, Smit *et al*. (2016:252) showed that if workers are involved in decision-making processes, they perceive themselves as active participants in the achievement of the set objectives. RN's will develop a sense of responsibility by being part of the decision-making and implementation plans. It will ensure more commitment. Therefore, regular meetings between managers and staff members could be a platform whereby RN's input is recognized — consequently enhancing the role of RN's towards the care of PWID's.

Communication about patient care should take place among nursing staff involved with the patients. In a horizontal flow of communication, sending and receiving of messages happens between individuals of the same hierarchy (Bergman *et al*., 2016:533-541). Horizontal communication may improve work relationships, as well as interaction between nursing staff. Such communication could help to coordinate care among nursing staff by sharing knowledge and experience promoting therapeutic nursing care

(Thompson, 2014:958). The following statements reflect the importance of communicating patient care:

> ***"Proper communication on each patient plan, or a goal, consistency for all staff to know what is expected."***
>
> ***"More detailed insight of what is good for different patients."***

Therefore, communication of patient care information can be through either meetings or other platforms. Effective communication requires specific interpersonal skills (Kourkouta & Papathanasiou, 2014:65-67; Frank-Bader *et al*., 2016:49-53;) that is necessary for therapeutic relationships and nursing practices.

3.4.2 Interpersonal relationships

An interpersonal relationship refers to a connection between two or more individuals, according to Sankaranarayanan & Sindhu (2012:151). Perry and Hall (2017:317) defined an interpersonal relationship as the individual's ability relating to others. Professional relationships develop as a consequence of good communication. These are important tools for quality professional practice among staff members.

Nursing is defined as an interpersonal and therapeutic process whereby nurses engage in therapeutic relationships with patients. Interpersonal communication is a vital element in nursing (Kourkouta & Papathanasiou, 2014:65-67). A therapeutic relationship is a basic element of effective communication between health professionals and patients. It also determines the quality of care rendered to the patients (Pazargadi *et al*., 2015:551-557; Frank-Bader *et al*., 2016:49-53). The RN's should interact with PWID's to establish therapeutic relationships.

Effective interpersonal relationships between RN's, patients and managers are essential to provide proper nursing care for PWID's. Poor, or conflicting, relationships may result in patient information not communicated and misinterpreted during service delivery. Inadequate information supplied during shift handovers results in negligent patient care and compromise safety (Weller *et al*., 2014:149-159; Vermeir *et al*., 2018:21-27). The characteristics of a nurse-patient therapeutic relationship include

respect, empathy, humour and patience (Moreno-Poyato *et al*., 2017:2-7). Nurses are required to demonstrate these skills when working with PWID's.

Nurses' lack of skills may inhibit their interaction with PWID's (Pazargadi *et al*., 2015:551-557). PWID's has physical, intellectual and social limitations that need a nurse's assistance, patience and support (Halter, 2018:30). They, therefore, need to learn therapeutic communication skills to develop a good nurse-patient relationship, as mentioned by the participants:

> **"*Acquire skills and confidence to know how to do the job re-intellectual disability."***
>
> ***"We must know the levels and how to work with different levels."***

This need of the participants is plausible in the light of appropriate communication skills required during nursing practices. Improved nurse communication skills will be important for effective communication between nurses and patients in a health care setting to address patients' needs (Kourkouta & Papathanasiou, 2014:65-67; Gordon *et al*., 2015:23-27). However, nurses spend limited time establishing therapeutic relationships with their patients (Frank-Bader *et al*., 2016:49-53; Popa-Vela & Purcarea, 2014:39-45). The following statements confirmed PWID's need undivided attention by the RN's:

> ***"These type of patients requires constant care."***
>
> ***"How much attention patient needs according to their disabilities?"***
>
> ***"Spend more time with patients, to identify patients' needs and focus on individual patient needs."***

However, the participants indicated that:

> ***"RN's doing a lot of paperwork and has no time for patients' care."***
>
> ***"Many papers are used for patient's records with long statements."***

Administrative work performed by participants seems to be a barrier to the nurse-patient therapeutic relationship and affects nursing care. Administrative workload impact on nurses' time and the availability to spend on patient care or to collaborate with other staff members (Kieft *et al*., 2014:249). Foronda *et al*. (2016:36-40) described

communication as an important factor for continuity in patient care. Wagner *et al*. (2015:974-982) proposed communication networks for staff members to interconnect, discuss work-related issues frequently and disseminate information. Effective communication networks might help to create a sense of job satisfaction and improve care delivery to PWID's. The participants believed that:

> **"*Trusting relationships, treating one another with respect and tolerating each other are essential."***
>
> ***"And try to understand each other as staff know why we are here."***

The participants explained the challenges they experienced, related to work relationships. Good interpersonal relationships among nurses contribute to less interpersonal problems, conflict and improve patient care (Kwateng, Osei & Abban, 2014:179-188). A ward manager has to establish productive interpersonal relationships between all nursing categories. Better work relationships and teamwork will be the product of effective managerial skills (Wagner *et al*., 2015:974-982). The participants' statements indicated that managers should be able to:

> **"*Manage conflicts and resolve problems as soon as possible.*"**

Effective managerial skills can contribute to the early identification and management of possible conflicts and staff problems by providing the necessary support.

3.5 Staff support

Staff support is an important human resource strategy that influences an employee's job commitment and satisfaction (Bishwajit *et al*., 2016:39-43). In a health care setting, nursing unit managers are registered nurse leaders with extensive clinical experience. Their responsibility is to supervise patient care and the support of nurses in the unit to improve job performance and satisfaction (Akremi *et al*., 2014:1185-1207). A nursing manager should also create a supportive work environment for all healthcare professionals to achieve high-quality patient care (Weldetsadik *et al*., 2019:131-135). RN's working with the PWID's 24/7 need more support from their managers, because they play a fundamental role in healthcare delivery. Effective support and mentoring from ward managers may improve RN's therapeutic role in caring for the PWIDs.

Supported nurses develop a more positive work attitude, leading to efficient patient care (Lawal & Idemudia, 2017:1-8; Khomami & Rustomfram, 2019:1850-1857). The participants felt strongly about management's role by saying that:

> ***"Management needs to show us they care, be visible."***

Besides managerial support, social support from colleagues is also important for RN's well-being and professional development. Peer support reduces stress levels and motivates people to perform better, achieving expected goals. This is contributed to the allowing of nurses to advise each other on personal and professional matters, together with developing teamwork and work engagement in a less stressful environment (Nasurdin *et al*., 2018:363-386; Mozaffar *et al*., 2015:1-8). Participants mentioned that colleagues should:

> ***"Encourage each other, trust, love and honesty as colleagues, able to share your own problems."***

This comment highlighted the need for peer support. Support from colleagues develops communication between health care professionals. This collaborative approach is necessary to promote teamwork and holistic care of PWID's. The following sub-themes are discussed:

3.5.1 Multidisciplinary approach

Haines *et al*. (2018:185-196) describe a multidisciplinary approach as a group of people from different professions collaborating and sharing expertise to the benefit of patient care. A multidisciplinary team in a mental health setting comprise of a nurse, doctor, occupational therapist, physiotherapist, psychologist, psychiatrist, dietician and social worker (Hughes & Hennessy, 2018:1-4). Discussions among team members influence patient care because of the sharing of information and knowledge. Additionally, ideas could be exchanged to improve patients' outcomes by solving their problems timeously, striving towards a mutual goal (Epstein, 2014:295-303, Kieft *et al*., 2014:249). Participants emphasised the need for a team member's involvement to care for PWID's and said:

"Involve multidisciplinary team, E.g. occupational therapist (OT), physiotherapist, dietician and social worker."

This view of the participants relates to their expectations from a multidisciplinary approach. A multidisciplinary approach has advantages for both the patients and health professionals, namely decision-making about patient care, the promotion of the continuity of care, a holistic view of patient needs, improved health outcomes and the enhancement of job satisfaction for team members (Liberati *et al*., 2016:31-39; Haines *et al*., 2018:185-196).

This approach promotes a supportive and stimulating environment for interaction amongst professionals to deliver holistic patient care (Hartgerink *et al*., 2014:791-799). RN's play a pivotal role in coordinating patient care and need support from other health care professionals. They should advocate PWID's health care needs to team members to ensure comprehensive care. PWID's will benefit from these inter-professional relations if RN's carry out team interventions to offer proactive nursing care. Ndoro (2014:724-727) mentioned that multidisciplinary teams are resourceful for health care professionals and help with the development of broader knowledge and skills to render improved patient care. The participants explained the importance of multidisciplinary teams for the nursing staff:

"Other team members will help us to increase our skills."

"*Multidisciplinary collaboration is needed for do-able ideas."*

"Meetings with other professionals to re-do and improve patient care."

Participants felt that collaboration amongst team members is crucial. Participating in multidisciplinary team meetings and team support increases team members' interest to perform their jobs and rendering better patient care (Hartgerink *et al*., 2014:791-799; O'Reilly *et al*., 2017:1-22). However, in a care-and-rehabilitation facility, multidisciplinary team meetings lack full representation of health care professionals, due to a shortage of staff. One of the participant's statements indicated a concern with regard to the shortages of other healthcare professionals to provide comprehensive healthcare services to PWID's**:**

"*There is a shortage of psychiatrists, occupational therapists and too few physiotherapists."*

Beside the opinions of the participants, a multidisciplinary team approach may invoke challenges regarding communication processes. There may be a lack of communication skills among team members and understanding of other member's roles. These deficiencies require an effective leader to ensure a functional multidisciplinary team (Hustoft *et al*., 2018:1-12). According to the participants, a team leader will help to**:**

"Understand the roles of each team member."

"Who can do what and how do we attain our goal?"

These participants' statements show the importance of a leader in a multidisciplinary team approach. Currently, multidisciplinary teams in the care-and-rehabilitation facility of this study comprise of a doctor, registered nurse, physiotherapist, occupational therapist, social worker and a dietician. The doctor plays the chairperson's role most of the time, coordinating PWID's presentations in multidisciplinary team meetings. However, Soukup *et al*. (2018:49-61) suggested that multidisciplinary team members should take turns chairing the meetings to improve teamwork and morale**.** Although multidisciplinary team members meet twice monthly to discuss PWID's in the facility of the study, there is still poor attendance of all team members. There is a lack to form a complete team. This is confirmed by the participants:

"Meetings with other health care professionals in a care-and-rehabilitation facility (Cosmos) are not a full team."

"Care of the users in totality need a complete multidisciplinary team more than a doctor, social worker and nurse."

From the participants' response, the importance of the multidisciplinary meeting is evident. The effectiveness of the multidisciplinary team meetings depends on the attendance of each team member to discuss the patients' goals, progress and problems. This is more crucial than the frequency of the meetings (Hartgerink *et al*., 2014:791-799). If team members are absent, it creates a gap in the information needed and may delay decision-making (Haines *et al*., 2018:185-196). Each multidisciplinary

team member's contribution will help RN's in the assessment of PWID's. It will help to identify their needs and draw up an intervention plan. However, Aston *et al.* (2018:218-223*)* reported that a sizable team might result in ineffective communication, because too much time may be spent to reach an agreement among team members.

Furthermore, a multidisciplinary team approach promotes person-centred care (PCC). In the case of person-centred care, the focus is on the individual patient care, which includes listening, informing and involving patients in their care (Hartgerink *et al*., 2014:791-799). This approach, if implemented effectively, will help RN's to meet the physical, social and psychological health care needs of PWID's. The RN's main focus should be on PWID's individualised care needs. This has to be addressed with the guidance of the multidisciplinary team. Clinical decisions taken need to be prioritised by the multidisciplinary team to provide successful patient-centred care for PWID's. For the reason that PWIDs' needs could change, a multidisciplinary team approach is required. They have to respond appropriately with their integrated expertise (Coetzee *et al*., 2019:1-10). The multidisciplinary team members should develop individualised short and long-term care plans, according to the identified patient's needs. It needs to be regularly reviewed for effectiveness (Hartgerink *et al*., 2014:791-799). Moore *et al*. (2017:662-673) highlighted the barriers to the successful implementation of PCC, such as staff attitude, time constraints, traditional practices and the institutional structure. Continuous peer, as well as management support, is necessary to implement positive PCC to care for PWID's.

3.5.2 Management support

Bishwajit *et al*. (2016:39-43) described management support as an organisational commitment toward employees. Perceived organisational support encourages job performance (Grama & Baias, 2018:16-19). To encourage nurses, performance managers should prioritise the nurse's needs to promote a positive practice environment for improved patient care delivery (Macauley, 2015:298-300). Previous studies describe a positive practice environment as a workplace that influences nurses' satisfaction and commitment (Lambrou *et al*., 2014:298-317; Munyewende *et al*.,

2014:1-14). Proposed suggestions by participants emphasising the above-mentioned were:

> ***"Management to show us that they care."***
>
> ***"Support staff affected when an unusual incident occurred. E.g. patient choking, make me feel that I'm not alone by showing we are in this together."***

It therefore seems like participants recommend management support to ensure therapeutic nursing care. Previous studies revealed that support from hospital management promotes nurses' job satisfaction, lessen turnover and decrease work stress. Lack of support from hospital management may lead to emotional fatigue, stress and lessen nurses' interaction with patients (Koy *et al*. 2015:1825-1831; Søndena *et al*., 2015:44-52). A stressful workplace is related to low work engagement (Mauno *et al*., 2016:1169-1181; Kurjneluoma *et al*., 2017:1048-1058; Lawal & Idemudia, 2017:1-8).

Therefore, the manager's supportive role should include the monitoring of working conditions to meet the nurses' physical and emotional needs. Nurses provide direct care for PWID's and may, due to their work demands, develop physical, emotional and medical disorders. Usually, nurses suffer from fatigue and stress when it comes to the care of people with severe and profound intellectual disability (Conradie *et al*. 2017:1-8). It is obvious that RN's in a care-and-rehabilitation facility should receive psychological support to lower workplace stressors and improve the care of PWID's. Participants felt that:

> ***"Emotional support is needed for motivation otherwise burnout."***

It is therefore quite understandable that participants feel demotivated if they do not get support. Emotional support to nurses reduces the level of frustration and stress in their work environment (Hashish, 2017:151-166). Nursing managers should adjust their leadership styles to support RN's caring for PWID's. Boamah (2018:9-19) and Morsiani, *et al*. (2017:119-128) discovered that transformational leadership support and stimulate nurses. It empowers them with knowledge and skills to initiate nursing care. Participants indicated that managers should:

"Provide guidance, advice and be supportive."

Participants expressed the need for discernible management support and effective leadership as requirements for enhancing nursing care. Transformational leadership also increases the retention of nurses, because of enhanced affective commitment. This leadership style is perceived by the nurses as respectful, caring for others, allowing professional development and appreciative (Kodama *et al*., 2016:884-892). It is beneficial if nursing managers empower RN's through transformational leadership to enhance their commitment to therapeutic caring practices and produce future ethical nurse managers.

The work environment influences a nurse's attitude. Hashish (2017:151-166) indicated that the impact could be on the ethical issues, job commitment and satisfaction. These elements involve the creation of an ethical work environment. An ethical work environment is guided by professional rules and standards, especially regarding dysfunctional behaviours. These directives might promote nurses' loyalty and reduce moral stress. That means that RN's should be supported and encouraged by their managers to report unethical practices freely during the care of PWID's. Participants said:

"Report any kind of abuse of patients to management."

An ethical work environment, as well as moral leadership, could inspire nurses to practice professional, ethical conduct when caring for PWID's. Chang (2014:332-340) proposed organisational justice as a further concept in an ethical environment for hospital managers to practice fairness in the allocation of resources, decision-making procedures and interpersonal interactions. Participants felt that:

"Nurses cannot raise concerns due to victimisation from management."

According to the participants, nurses should have the freedom to talk about challenges related to the care of PWID's. They should be able to give their inputs to prevent job dissatisfaction. Job satisfaction is the extent to which an individual like or dislike his or her job (Wan Yusoff *et al*., 2013:18-22). If nurses are included in clinical decision-making processes, it will boost their interest in their tasks and also uplift their performance (Macauley, 2015:298-300; Hall *et al*., 2016:1-12). Engaging staff during

decision-making processes create positive relationships, motivating them to partake more in work activities. This depends on individual willingness and dedication (Bunchapattanasakda, 2019:63-80). Participants emphasised the importance of their involvement in decision-making and stated that:

"*We want to be involved in new information introduced.*"

"*Staff should be asked for inputs, not just give instructions.*"

Participants' statements implied that managers should involve RN's in decisions affecting PWID's care. They should listen to their views. Nurses coordinate patient care as frontline health care providers. Therefore, their contribution to patient care needs to be valued (Lawal & Idemudia, 2017:1-8; Er & Sokmen, 2018:206-212; Nasurdin *et al*., 2018:363-386). Participants highlighted the importance of acknowledging and appreciating the RN's good performance by their managers:

"Recognise hard work, appreciate and say thank you."

A manager's appreciation of RN's performance will positively reinforce and motivate them to deliver care beyond role expectations. Motivation is described as the individual willingness to exert an effort to achieve organisational goals (Wan Yusoff *et al*., 2013:18-22). Motivational support of nurses, discussed according to Hertzberg's two-factor theory (1959) theory, stipulate two factors that have an impact on job satisfaction and dissatisfaction. Job satisfaction depends on motivation factors while dissatisfaction on hygiene factors. Mullins (2016:232) further describes Hertzberg's two factor theory as the hygiene and motivational theory or growth for staff support. Hygiene factors (extrinsic) dissatisfy the workers if not addressed. These factors include salaries, job security, institutional policies, working conditions and learning opportunities.

Wan Yusoff *et al*. (2013:18-22) argued that hygiene factors (extrinsic) could only meet the lower-level needs of the employees. This means that the employees are not motivated from within themselves to put the effort in the performance of their jobs. In contrast to that, the employees will be motivated by the following motivational or growth factors (intrinsic): a sense of achievement, responsibility, the nature of work in relation to personal growth and development.

According to Wei *et al*. (2018:287-300), a nurse's job performance and productivity can be promoted if the extrinsic and intrinsic motivational factors are met. The motivation of the RN's could be from external factors or those within the job. Poor hygiene factors might decrease the nurse's job satisfaction while improved motivational factors (intrinsic) increase job satisfaction. Damij *et al*. (2015) showed that various factors could be motivators or inhibitors for work performance. For this reason, the managers cannot rely on a single factor alone to motivate RN's during the performance of their tasks.

Hospital management could allay staff fears during care delivery by ensuring a safe and conducive environment that increase staff motivation. A healthy work environment reduces the nurse's level of job stress and improves patient safety (Van Bogaert *et al*., 2014:343-355).

3.6 Healthcare environment

A healthcare environment refers to a setting in which healthcare is delivered (McCormack & McCance, 2017:47). A healthcare environment should be safe to protect staff, patients and visitors from any physical, psychological and psychosocial factors. RN's are the primary health care providers delivering patient care 24hours. Therefore, they must create, facilitate and maintain the PWID's therapeutic milieu. The therapeutic milieu is a physical, social and psychological environment created for continuous patient recovery or healing. It also ensures a patient's safety, comfort, support and respect of their dignity (Smith & Spritzmueller, 2016:105-116). The environment affects the social and psychological functioning of the patient (Kieft *et al*., 2014:249). Patients learn adaptive coping mechanisms and positive interpersonal relationships in the therapeutic environment (Lok & Buldukoğlu, 2015:114-137). RN's could influence the physical and social environment for PWID's to learn new skills and participate in social activities.

Safety and security similarly characterize the therapeutic environment, indicating a basic human need. According to Maslow's hierarchy of needs theory the well-being of (Booysen, 2008:458-459), both the patients and staff require a physical health care environment that supports this human need (Anaker *et al*., 2017:136-150). The physical

surrounding for patients and staff must be conducive by limiting potential harm (Craven, Hirnle & Henshaw, 2017:574; Perry & Hall, 2017:373-374). According to the Occupational Health and Safety Act (No. 85 of 1993), safety implies a state of being free from harm or danger. Safety in health care institutions is a global concern (WHO, 2015). It incorporates the physical and psychosocial elements to ensure optimal patient care (Conray *et al*., 2017:53-63). The participants were concerned about:

"Environment that is safe for patients and staff."

The health care environment and the protection of patients and staff should be a priority, according to this statement. Previous research by Okeke and Mabuza (2017:1-7) added the presence of adequate security personnel as important elements for safety and security in health care institutions. For the safety of staff and PWID's, participants mentioned that:

"Security for 24/7 at the facility is also needed in patient's care areas."

"RN's will also feel safe and supported to do better work."

Participants raised concerns about their safety to provide health care services to PWID's in insecure ward environments. Risk management and continuous improvement of the patient environment is necessary to provide safe patient care (Top & Tekingunduz, 2015:87-110; Jones & Johnstone, 2019:151-157). Risk management entails the assessment of risk factors and the implementation of safety measures to reduce potential risks (Bayramzadeh, 2017:66-80). Therefore, assessment of the hospital infrastructure for safety is necessary. Poor infrastructure in the hospital environment exposes staff and patients to occupational health hazards, according to the Occupational Health and Safety Act (85 of 1993). Infrastructure maintenance is necessary to ensure a safe environment for staff and PWID's. The participants specified certain areas that need to be improved:

"Buildings are tatters".

"*Replace windows."*

A safe and healthy work environment has a positive impact on the work attitude of nurses, their health, physical and emotional well-being. It influences nurses to deliver safe patient care (Park & Kim, 2018:1605-1606). At the same time, unhealthy work

environments expose nursing staff to stress and burnout. This results in unsafe nursing care rendered to patients (Zerwekh & Garneau, 2012:322).

In terms of the National Health Act (No. 61 of 2003), the National Department of Health (NDoH) developed the National Core Standards (NCS) for health establishments in South Africa to monitor the quality of health care delivery. Some of the six priorities of the National Core Standards include patient safety and security, cleanliness, infection prevention and control (Department of Health, 2011). Participants felt that there should be:

Clean environment (hygiene of the ward) to nurse patients."

"Ceilings are dirty."

For the prevention of infections in the wards, RN's are obligated to follow the stipulated infection control guidelines to maintain a safe and infection-free ward environment for PWID's. Those preventative measures also involve the use of personal protective equipment (PPEs). PWID's do suffer from communicable diseases in the wards and RN's must protect themselves and other patients from contracting diseases. Lack of proper personal protective equipment exposes nurses to occupational health diseases, as stipulated by the Occupational Health and Safety Act (No. 85 of 1993). Participants highlighted this issue in the succeeding comment:

"***Quality medical consumables that protect staff when used, like mask for Pulmonary Tuberculosis (PTB) or any disease outbreak."***

This statement gave rise to the participants' concerns related to their personal protection. Health care providers are at risk of occupational diseases and injuries. One example of physical harm is musculoskeletal injuries. This occurs more among health care providers than on other types of workers (Okuyama *et al*., 2019:216-222). This is due to physically demanding work that exposes nurses to back injuries. It often relates to mobilising patients with physical disabilities. The participants illustrated that:

"*Nurses do lifting in and out of bath is back hurting."*

Such a statement is a good illustration of staff injuries that can occur. This may lead to more sick leave taken, increasing absenteeism and subsequently staff shortages. This

shortage of nurses further increases the risk of PWID's incidents resulting from seclusion and restraints. Examples are self-harm and falls during service delivery (D'Lima *et al*., 2017:241-243; Dewa *et al*., 2018:1-8). RN's should supervise PWID's and prioritise their safety. The participants proposed that PWID's environment should:

"*Ensure safety in the seclusion room remove all harmful objects."*

"Hazard free environment."

These statements justify that RN's have the responsibility in the wards to prevent patients' incidents by assessing the PWID's milieu. Risk assessment entails monitoring of PWID's mobility and abnormal behaviours. This is to minimise the risk of falls together with other potential injuries. PWID's are at risk of falls and injuries due to their physical and social challenges that affect their mobility and behaviour. The risk factors related to PWID's incidents include impaired mobility, old age and epilepsy with behaviour problems (Devinsky *et al*., 2015:1510-1521). Perez *et al*. (2017:737-754) reported another risk factor with the description of problems among PWID's. It relates to meal times and the risk of choking. The participants also raised this issue when they stated:

"Wards are not the same; some have the increased risk for choking."

RN's should be alert for possible incidents related to PWID's disabilities and report them to reduce the occurrence and prevent more harm. Reporting enable the establishment of quality improvement projects to address mistakes, prevent reoccurrence and provide better nursing care (Hazan, 2016 83-87). Nurse's inadequate knowledge and skills could challenge the managing of incidents of patients. Park & Kim (2018:1605-1606) reported that the lack of nurses' clinical skills is also a risk to render safe care to patients. Education of nurses is important to increase their clinical confidence for safe nursing care to PWID's. A care environment that supports and empowers nurses reduces the level of patient's incidents and medical errors (Kieft *et al*., 2014:249; Boamah, 2018:9-19; Lee & Scott, 2018:121-145; Wei *et al*., 2018:287-300).

A safe and therapeutic milieu will contribute to better nursing care delivery by RN's working with PWID's in care-and-rehabilitation wards. Care delivery is the next theme to be discussed.

3.7 Care delivery

Care delivery in health care is the provision of health care services to patients. Quality and holistic health care service delivery consists of four steps, namely assessment, diagnosis, management and monitoring patients (Havaei *et al*., 2019:1-10). According to the Nursing Act (No. 33 of 2005), RN's should have the knowledge to assess, diagnose and treat patients, including PWID's. A response from one of the participants was that:

> ***"Registered nurses should do assessments that will help in diagnosis of patients."***

The nursing care plan stipulates assessment of PWID's and formulating a nursing diagnosis., RN's learn it during their training, which makes this response perhaps redundant. Nursing care delivery implies that nurses work independently or collaborate with other health care professionals to provide continuity of patient care. That involves multidisciplinary team members working together with the patient family members to focus on individualised health care needs of PWID's (Havaei *et al*., 2019:1-10). Sheehan *et al*. (2016) suggested that individualised patient care is required to address poor hospital care for PWID's. The patient-centred care approach considers a patient's preferences, needs and values in routine activities (Gabutti *et al*., 2017:1-16), RN's should put PWID's at the centre of care by treating them with dignity, respecting their preferences and needs. One participant stated:

> **"*Focus to be on individual patient needs*."**

This response indicated the need for patient-centred care in the safekeeping of PWID's. The principles of patient-centred care include coordination and integration of care, physical comfort, emotional support, education and family involvement. This is essential in the continuity of care (Cramm & Nieboer, 2017:1-11; Delaney, 2018:119-123). Supporting patients emotionally requires nurses to be friendly and approachable, by building a trusting relationship with patients and their relatives (Ross *et al*., 2015:9-

10). This means that health care providers should involve PWID's and their families by providing them with information about intellectual disability care to make informed decisions. One of the participant's ideas was to:

"Explain to the family what we offer to the patients."

The role of the family in the care of PWIDs could also positively contribute towards RN's therapeutic role in a care-and-rehabilitation ward, which is seen in the participant's response. The following section will discuss the sub-themes related to care delivery, namely community and family involvement, rehabilitation, as well as a stimulation program on activities of daily living.

3.7.1 Community and family involvement

The community and family provide social support in the care of patients. The involvement of the patient's family is a significant element of patient-centred care (Jardien-Baboo *et al*., 2016:397-405). The relationship and communication between RN's and the families of PWID's are essential to facilitate patient-centred care. This partnership assists the nurses in providing better care for PWID's (Kenten *et al*., 2019:1176-1183). Family history is important to assist in the diagnosis and treatment of PWID's. The challenge faced by the RN's is that most of PWID's admitted in a care-and-rehabilitation facility lack family contacts. This creates a problem to integrate and involve families of PWID's to participate in their care. The participant's concern was:

"Some families stay far."

Participants highlighted the need to contact PWID's families, engaging them in PCC. Glasper (2017:63-67) mentioned that to provide the best care for PWID's, families should be engaged during admission. Family interaction assists PWID's to develop social interaction skills and relationships with their peers. This help to control and limit abnormal social behaviour (Floyd & Olsen, 2017:203-2011). Community participation in PWID's care should be encouraged for support to avoid abuse and discrimination (Amado *et al*., 2013:360-373). The participants agreed that:

"Family and community involvement is important."

"*Patient originates from the family, encourage family to visit patients."*

Encouraging community participation and family visits will thus be supporting the RN's therapeutic role towards PWID's. Bullen *et al*. (2018:1-10) stated that parents and visitors should be encouraged to support PWID's in the achievement of their stimulation goals by educating them. Parental education on PWID's care promotes awareness, activates participation and reduces stress (Machalicek *et a*l., 2015:110-118). As the participants realised it, they expressed:

> **"*Young mothers do not understand why they have children like this and have anxiety re child's condition."***
>
> ***"Explain to the family what their role is and what to expect during child development?"***

Parental knowledge and skills will be helpful for the continuous care of PWID's, even at home. PWID's should receive care, treatment and rehabilitation in a care-and-rehabilitation setting, according to the Mental Health Act (No. 17 of 2002).

3.7.2 Rehabilitation

Rehabilitation is a process that enables the attainment and maintenance of physical, mental and social activities for people with various health conditions and disabilities (Stefano, 2018:125-155). Sechoaro *et al*. (2014:1-9) described rehabilitation as a goal-orientated process to reduce functional impairment of PWID's. This is an ongoing process to empower PWID's to function at an optimal level mentally, physically and socially. Rehabilitation also involves individual assessment, planning, implementation and evaluation by a multidisciplinary team of health care professionals (Van den Driessen Mareeuw *et al*., 2017:1-15). In this study, rehabilitation for PWID's in a long-term care setting comprised of those with mild, moderate, severe and profound intellectual disabilities. One participant stated the need for the rehabilitation of PWID's:

> ***"Rehabilitation of patients not only on eating or bathing, patient's conditions deteriorate."***
>
> ***"Physiotherapist helps with a plan and movements to stimulate patient's muscles."***
>
> ***"Show us how to handle and feed spastic patients."***

Participants' statements claim the importance of help from other team members to guide them in the rehabilitation process. Multidisciplinary team intervention is required for successful rehabilitation of PWID's (Van den Driessen Mareeuw *et al*., 2017:1-15). This is also explained one participant's statements:

> ***"Individual program for each patient by occupational or physiotherapist, nurses to implement and maintain."***

Although this statement mentions the need for individual programs by occupational or physiotherapists, it has to be asserted that RN's received training on developing stimulation programs for PWIDs during their undergraduate studies. This leads the researcher to ask whether RN's feel inadequate or if they are not motivated to develop stimulation programs. Whichever the reason may be, PWID's need individualized treatment to maximise their functioning. This involves stimulation in activities of their daily living.

3.7.3 Stimulation and activities of daily living

Mikołajczyk and Jankowicz-Szymańska (2017:102-109) describe stimulation of PWID's as a process to teach them skills to develop independence in activities of daily living (ADL). These are, for example bathing, dressing, feeding and communication skills. The purpose of stimulation is to develop PWID's mental, physical and sensory abilities (Van der Putten *et al*., 2017:1-11). Munde and Vlaskamp (2015:284-292) argued that incorporating different stimuli, such as visual, tactile, auditory and vestibular, promotes a state of being alert in people with profound intellectual disability. Wiese (2018:1-6) revealed that sensory stimulation, such as therapeutic music, is essential to relax and control PWID's emotions. According to the participant's statements:

> ***"All patients need some stimulation and other skills."***

> ***"Focus should be on activities of daily living, improvement according the functioning levels."***

> ***"Occupational therapist can help to show RN's how to group accordingly."***

Effective implementation of the stimulation program for PWID's develops skills and independence in activities of daily living. Most of PWID's daily activities most probably

need supervision (Sandjojo *et al*., 2018:840-850). Marrus and Hall (2017:539-554) indicated that PWID's could benefit from early intensive interventions for their specific developmental delays. Long-term interventions and consistency are required to increase PWID's independence in activities of daily living.

In reflection, RN's spend most of their time next to the patients and should stimulate PWID's as part of their therapeutic role. However, stimulation of PWID's remains a challenge for the RN's to initiate and maintain in the wards. This is regardless of the training obtained by RN's in their care-and-rehabilitation facility. On the one hand, it could be that RN's are not dedicated enough to engage in stimulation activities or otherwise the problem may be the inability of RN's to apply acquired knowledge and skills. If this is the case, then the need for management support and continuous training becomes clear.

3.8 Education

Sankaranarayanan and Sindhu (2012:2-3) defines education as a process to acquire the knowledge and skills needed by a specific profession. Additionally, Erasmus *et al*. (2006:2) described education and training as a process whereby employees can acquire and apply knowledge, skills and attitude to achieve institutional objectives. In terms of the Nursing Act (No. 33 of 2005), nursing education involves theoretical and clinical training to qualify as a nurse**.** Nurses receive education in the classrooms and clinical environment during training in the colleges and universities. In these settings, they have to practice nursing, as well as develop personally and professionally. In nursing training institutions, nurses learn cognitive, psychomotor and affective skills to render therapeutic patient care (SANC, R425). Clinical training is a vital part of nursing education to establish RN's clinical competency in patient care. Participants argued:

> **"*Train and retrain on how we nurse the patients with intellectual disability."***

Psychiatric nursing science is part of the RN's training curriculum to render mental, rehabilitation services for both PWID's and mental illness. This training prepares RN's to render correct and safe mental health care services (SANC, R425). However, some RN's in a care-and-rehabilitation facility practice without psychiatric training. They are

qualified in general nursing or midwifery, from the nursing training programs previously presented to them. Consequently, this creates a need for proper orientation, mentoring and training required to care for PWID's. The following sub-themes will be discussed.

3.8.1 Orientation and induction

Orientation and induction is the process to introduce and integrate new employees into an organisation. Employees receive guidance on the organisation mission, objectives, job responsibilities and the expected code of conduct (Booysen, 2008:381). Xie *et al*. (2018:1-6) explained that the orientation of the newly appointed nurses is to clarify their expected roles. The main purpose of orientation and induction is to reduce new employee's anxiety levels and uncertainties, which can result in frequent turnover. Orientation and induction program increase work performance, commitment and retention of new nurses (Ivancevich & Konopaske, 2013:393-394). Hence, proper orientation and induction in care-and-rehabilitation are very crucial to clarify RN's therapeutic roles towards PWID's. The participants explained the needs of newly employed nurses as:

"Orientation and induction program for new staff."

"Orientation and induction form part of employees mentoring."

Participants' comments reflect the importance of an orientation and induction program through mentoring to help them adjust to a new environment. Mentoring could be another strategy to train and develop nurses in health settings.

3.8.2 Mentorship

Mentoring means a one to one relationship between a mentor and mentee. This may lead the individual to potentially develop personally and professionally enhancing performance and achievement of career progression (Mullins, 2016:170). Bruce *et al*. (2011:353) added that mentoring is a career development relationship that fills the gap of knowledge and skills related to new surroundings. In nursing education, mentorship is a teaching and learning process acquired through personal experience. It is facilitated by a one on one relationship. A mentor acts as a role model to support, develop and engage the mentee in the clinical setting (Seekoe, 2014).

In a psychiatric clinical setting, mentorship assists to calm the newly appointed nurses, built confidence and address misconceptions about mental health (Harding & Mawson, 2017:1-9). Due to the retirement of most senior and skilled RN's, the institution often loses experienced mentors causing newly graduated nursing professionals to start working without mentoring in the new work environment. Newly graduated nursing professionals therefor regularly lack mentors to impart knowledge and skills in the clinical environment. Senior RN's with extensive work experience could contribute by sharing their knowledge and skills with junior professionals. They may help in capacity building by addressing PWID's special needs. Participants illustrated that:

> ***"RN's should mentor junior nursing staff on how to execute duties in line with their scope of practice."***
>
> ***"Confidence to know how to do the job is built by mentoring."***

The participants highlighted the role of mentorship as an important factor in acquiring therapeutic nursing care knowledge and skills. In the process of mentoring, senior RN's will be providing clinical support and skills training to newly appointed nurses that will aid their clinical competence.

3.8.3 Skills training

Providing clinical skills training may address the ever-changing training needs, because of challenging health care problems. Clinical training of nurses improves their capability to render quality nursing care (USAID, 2010). Skills training is paramount in nursing education to promote RN's clinical competency in patient care:

> **"*Train and retrain on how we nurse the patients with intellectual disability."***
>
> ***"In-service training for nurses on new information, procedures that change considering services we give."***

Although RN's received formal training on intellectual disability care during their undergraduate studies. The participants felt that regular in-service training should follow when working at care-and-rehabilitation facilities. The student nurse's clinical exposure is about 150-200 hours in care-and-rehabilitation settings during their studies.

In this limited time frame when placed, learners are supposed to acquire the necessary skills to care for PWID's. It becomes difficult for the RN's to integrate knowledge into practice after completion of training if they are not adequately prepared. Hence, the participants recognised that:

"*It is confusing in a real ward than in the book you cannot apply it*."

This comment emphasized the participants' opinion that theory and practical integration need reinforcement to improve therapeutic nursing.

PWID's have multiple deficits that need specialised nursing care. Such deficit areas include intellectual, social and daily functioning (Halter, 2018:180). The severity of their disabilities ranges from mild to profound. PWID's become dependent on nurses to cope daily due to the severity of their disabilities. Proper and adequate clinical training for RN's is a prerequisite to care for PWID's, as indicated by Malapela *et al*. (2017:1-10). Nurses must be adequately trained to meet PWID's special care needs. Statements expressed by the participants about training were**:**

"*Train and develop to acquire skills.*"

"*More detailed insight of what is good for different patients and know patients functioning levels."*

"How much attention the patient needs according to the disability."

Although most of the participants had a psychiatry qualification, continuous professional development is important. Continuous professional development plays a major role in health care settings by equipping nurses with knowledge and skills to be competent health professionals (Filipe *et al*., 2014:134-141; Manley *et al*., 2018:134-141). RN's need opportunities for continuous training and development to update their knowledge and skills. Besides the institution providing continuous training and development opportunities, RN's should also look for self-development opportunities. There are other voices, like Draper *et al*. (2016:30-36) who found limited evidence supporting the effect of continues professional education on health care outcomes.

To add to the importance of training, the Life Esidimeni report by Makgoba (2017) found that PWID's rights were violated due to the lack of the necessary clinical skills

from the staff. Those investigations showed actions of negligence and irresponsible care received by PWID's from unskilled staff. It is also imperative for the RN's to demonstrate an understanding of the legislation and policy frameworks that influence the nursing profession for them to render health care services for PWID's adhering to legal requirements.

3.9 Legislative and policy framework

Legislative frameworks are acts, procedures, regulations and policies that guide the delivery of services. In the health profession, these legislative frameworks guide and control the behavior of health care professionals in practice (Watson & O'Connor, 2017:305-312; Ayano, 2018; Singh & Mathuray, 2018:122-139). Health care professionals are obligated to provide proper and safe health care services to the public.

In terms of Section 27 of the Constitution of the Republic of South Africa 1996, access to health care is a human right. The Constitution prohibits unfair discrimination against anyone on the grounds of disability by protecting all citizens' human rights to receive treatment that respect their dignity. The National Health Care Act (No. 61 of 2003) stated that the provision of social, physical and mental health care services is the main function of the National Department of Health (NDoH). The Act regulates health care services rendered to the patients and vulnerable people with disabilities.

For the nurses, the Nursing Act (No. 33 of 2005) regulates the nursing profession in South Africa to render holistic and quality patient care. It outlines the scope of practice for nurses, as well as the conditions under which all nursing categories should perform their roles. The scope of practice legally guides nurses in their clinical practice to prevent patients' harm and neglect, may it be from unqualified nurses (SANC, R2598). This means that nurses' delegated roles should be according to their scope of practice to render competent nursing care to PWID's. As the participants mentioned in their statements:

> **"*Duties delegated according to the scope of practice."***
>
> ***"Good delegation principles otherwise, we can compromise and reduce quality."***

Participants indicated that adherence to SANC regulations by the RN's, when performing their tasks, is crucial. Another statutory body that regulates the professional standards and conduct of the nurses is the South African Nursing Council (SANC). The SANC set the code of nursing ethics for nurses to make ethically sound decisions during service delivery. It includes beneficence, non-maleficence and justice. According to the Nursing Act (No. 33 of 2005), nurses are required to render good health care services with no harm and fair treatment to all the patients. They remain accountable for their acts and omissions. Therefore, RN's are accountable for the tasks carried out or omitted during care of PWID's. The participants' statements indicated some concerns:

"Do no harm, follow policies and procedure."

"Give correct treatment following medication rules."

These concerns mean that the RN's should familiarise themselves with the legal and ethical frameworks that regulate the nursing practice. For delivery of quality nursing care, the nurses should understand their legal responsibilities, obligations and implications (Perry & Hall, 2017:302; Singh & Mathuray, 2018:122-139). RN's should comply with the set of statutory legislations, care standards, policies and procedures**.** All these legal frameworks will guide RN's to provide safe and legitimate nursing care for PWID's. Additionally, Batho-Pele is also a framework that guides health care professionals during patient care.

3.9.1 Batho-Pele Principles

The White Paper (1997) on the transformation of public service delivery, namely Batho-Pele, translates to people first. The aim of Batho-Pele, as introduced in South African public health care institutions, is to better public service delivery and putting people first. The eight Batho-Pele principles include consultation, access, courtesy, service standards, the value of money, openness and transparency, information and redress. Application of these principles by the RN's will ensure dignified delivery of health care services to PWID's and their families. The participant's statements acknowledged that:

"We are the arm of the public service Batho-Pele principles should guide us."

"If we implement and do the right way, it will be quality care."

It, therefore, seems that adhering to ethical principles as expected of RN's is essential to conduct therapeutic nursing care. This is confirmed by the comments of the participants. Nurses should treat PWID's with respect, consult their families, give the necessary information during care delivery supporting their human rights and realising the patient's rights charter.

3.9.2 Patient's Rights

The Patient's Rights Charter is an ethical guideline for professional practice in a health care setting (South Africa National Department of Health, 2011). The Department of Health (DoH) developed the Patient's Rights Charter (1999) as a common standard to realise an individual's constitutional rights. Those rights include access to health care services by PWID's, to being treated equally and no discrimination based on their mental status or physical disabilities. McKenzie (2016:67-78) explained that PWID's also have the right to freedom, maximising their social independency as human beings.

The nursing profession should embrace the Patient's Rights Charter to prioritise PWID's welfare and interests. Watson and O'Connor (2017:305-312) indicated that nurses are patients' advocates and they should protect PWID's rights. Therefore, advocacy is one ethical principle that nurses should demonstrate to protect the rights of PWID's, because they are vulnerable and unable to verbalise or demand their rights (ANA, 2019). RN's should advocate PWID's rights. The opinions of the participants were:

"Advocate if patient do not get proper food comment."

"Getting legal consent is the right of the patient."

"Maintain privacy and confidentiality."

To adhere to these patients' rights, participants stressed their statements as a standard for therapeutic nursing care. Advocacy involves reporting unethical health care practices against PWID's, including those with severe and profound intellectual disability. The participants showed concern to protect PWID's rights:

"Report any kind of abuse of patients to management and authorities (E.g. Police)."

Another aspect underscored by the participants' concerns, is formulated by the Mental Health Act (No. 17 of 2002). It protects the rights of people with mental illness and intellectual disability in mental health care institutions from any kind of unfair discrimination, abuse and exploitation. The purpose of the Act is to ensure that patients receive equitable, efficient mental health care, treatment and rehabilitation services. RN's should comply with the Health Care Acts, institutional policies and standard operating procedures (SOPs) to deliver competent care and treatment of PWID's. Set policy and procedures are there to assist RN's delivering patient care.

3.9.3 Policy and procedures

Roussel and Swansburg (2009:486-487) referred to policy and procedures as directives for the daily operations of an institution and management resource tools for the employees. The institution communicates its objectives to the employees and describes their roles and responsibilities. Policies and procedures give guidance, outline and describe actions of employees to complete their tasks (Ellenbecker & Edward, 2016:208-217; Campos & Reich, 2019:224-235). One example may be standard operating procedures (SOPs) in nursing that state clearly how to perform specific clinical routine activities by the responsible nurse (Shestopalova & Gololobova, 2018:129-137).

RN's should comply with the designed policies and procedures to render safe and cost-effective nursing care to PWID's. This will assist in the accomplishing of the institution goals. There may be challenges experienced during the policy implementation process such as availability of resources, managing conflict, maintaining cooperation and sustaining policy changes (Campos & Reich,2019:224-235). The participants disclosed that policy and procedures are resourceful to the nurses despite these challenges:

"Policies and procedures instill confidence, sense of security and reference."

"New staff needs to refer to when not sure, understand and apply."

The participants' other concerns were:

> **"*Policies and procedures availability."***
>
> ***"How they apply in here?"***

Apart from these statements, the institutional policies, procedures need to be relevant and understandable for RN's to apply effectively. If a policy is not specified, it becomes difficult for staff to implement and it may hamper the delivery of patient care. The following statement confirmed this:

> **"*Make a policy applicable to the needs of the patients at the institutional level."***

The participants related effective communication of policies to the enhancement of therapeutic care. There are different categories and hierarchy levels of nursing staff in a health care environment. This may contribute to the misinterpretation of policies by times (Erasmus *et al*., 2017:1-14). Previous research by Ditlopo *et al*. (2014) suggested that nurses can contribute to policy development processes by evaluating their own views. This may assist to prevent the misinterpretation of the policies. The participants expressed themselves on the policymaking process in the following way:

> ***"Staff in contact with the patients (PWID's) should be involved in making policy and procedures.***
>
> ***"We will help."***

These proposals from the participants reflect their sentiment regarding policymaking decisions. RN's have direct contact with PWID's daily, which put them in a better position to provide vital information to influence policies for health care delivery. Participants expressed barriers that they experience in the implementation of policies and procedures:

> ***"Considering policies and procedures they are limiting can be a stumbling-block, cannot be done."***
>
> ***"For example, buying-in care standards used for general hospitals."***

From the participants' statements, the application of policies and procedures by RN's in a care-and-rehabilitation facility appeared to be a problem. This hampers the realising

of their therapeutic role. Arabi *et al*. (2014:536) reported that nurses must know, and understand the health care system to influence health care policies and build leadership roles. Also, it was stated that they have to advocate for better nurse patient ratios and access to the required resources to improve patient care.

3.10 Resources

Resources are tools workers need for effective delivery of services (Manyisa & Van Aswegen, 2017:28-38). This researcher found that mental health and public hospitals globally encounter poor infrastructure and a shortage of staff. A similar study by Masa'Deh *et al*. (2018:115-119) reported that a lack of resources contributes to high levels of stress among nurses working in mental health settings. Nurses are at risk of developing stress, fatigue and medical disorders because of inadequate resources and poor working conditions. They experience a sense of guilt and frustration to render safe nursing care, which often results in malpractice and legal actions against the institution (Moyimane *et al*., 2017). In terms of Section 27 of the Constitution (1996), the lack of physical and human resources will be violating the patients' human rights. Adequate physical resources are essential for nurses to render complete patient care. Physical and human resources as a sub-themes discussion will follow.

3.10.1 Physical resources

Physical resources involve tangible, material objects used by the workers to perform their duties, such as equipment (Scott *et al*., 2018:1-12). Inadequate physical resources are some of the barriers to render quality nursing care to the patients (Rivaz *et al*., 2017:1-4). Inadequate resources were detailed by the participants:

> ***"If no linen, we cannot make beds to prevent bed ulcers."***
>
> ***"Equipment's availability and medical consumables like intravenous lines, gloves and plaster we have to improvise."***

The participants thus implied that a lack of the necessary material and medical equipment might hinder nursing care resulting in the delay of PWID's assessment, diagnosis and treatment. The PWID's medical conditions are often complicated. With lack of resources, nurses become detached from patient care, resulting in negligence

(Moyimane *et al*., 2017). The participants clarified equipment and medication challenges as follows:

> ***"Well-functioning equipment will help with assessment of patients."***
>
> ***"Medication is off-code or out of stock; only affordable medications are available."***

In addition to medical equipment, medication appeared to be inadequate for the treatment of PWID's, as highlighted by the participants. Hospital patients' clothes also form part of the physical resources and care environment. Patient clothing is important for personal identity, physical wellbeing and the maintenance of their self-esteem during hospitalisation (Liu *et al*., 2016:390-393). The patients should be well dressed, comfortable and confident. Participants described problems experienced with patients' clothes:

> ***"Appropriate (correct sizes) patient's' clothes and shoes are not available."***
>
> ***"Problem-getting clothes back from laundry."***

The reason for these challenges indicates the negligence of a basic human rights need. Proper in-patients clothing should be a priority to protect their dignity and good appearance to the public. Managers should ensure an adequate supply of physical resources together with human resources for nurses to care for PWID's.

3.10.2 Human resources

Human resources refer to personnel in the institution (Ambikile & Iseselo, 2017:1-13; Manyisa & Van Aswegen, 2017:28-38). A shortage of mental health care nurses is a global and a national crisis in health care institutions (De Kock & Pillay, 2016). Inadequate human resources have a negative influence on the well-being of the nurses that do care for PWID's. This is due to the physical and mental impact accompanying this type of nursing care (Ambikile & Iseselo, 2017:1-13). Masa'Deh *et al*. (2018:115-119) agreed that high stress levels affect nurses' physical and psychological status, leading to work dissatisfaction and burnout. Nurses perform physically and mentally demanding tasks that involve mostly care of patients with severe and profound

intellectual disabilities. These type of patients depend on the nurses for almost all self-care activities, such as feeding and bathing (Conradie *et al*., 2017:1-8). This creates a need for adequate nursing staff to give PWID's attention. Participants said:

"We can focus on patient individual needs patients will get the best care."

"It will help us with goal-orientated care, like one nurse to four patients (1:4)."

"*Workload and nursing staff-patient ratio's is a problem."*

Participants' statements outlined problems associated with their workload, which influence therapeutic care delivery. Manyisa and Van Aswegen (2017:28-38) define workload as one of the factors that cause nurses' job dissatisfaction and dehumanisation of patients. Conradie *et al*. (2017:1-8) further illustrated that workload is one of the main occupational stressors experienced by the nursing staff caring for PWID's. Patients' adverse events, such as falls, injuries and medication errors often increase due to inadequate nursing staff and inappropriate nurse-patient ratios (Scott *et al*., 2018:1-12; Rivaz *et al*., 2017:1-4). Participants also indicated that:

"*There are less adverse events if enough staff is on duty."*

Adequate nursing staff in the wards, according to the participants, minimise the occurrence of PWID's incidents. Therefore, nursing staffing measures applied in the wards should consider nurse-patient ratios. Nurse to patient ratio refers to the number of nurses on a shift compared to the number of patients receiving care in a unit. That means the number of patients assigned per nurse on duty (Min & Scott, 2016:439-448; Driscoll *et al*., 2018:6-22; Paulsen, 2018:42-48). Therefore, lower proportions of RN's to patients in the wards put them under pressure to complete their tasks. RN's ability to identify PWID's needs and provide appropriate intervention is then restricted. Endsley (2017:43-52) also revealed that omitted nursing care tasks is associated with a higher workload on those RN's available and a lack of time for the nurses to finish the allocated tasks per patient. The participant's statements clarified that:

"Adequate staffing is needed so that all roles can be carried out to prevent frustration."

"RNs will feel encouraged to provide correct care."

"Not a marathon to ensure that everything is done. Otherwise, you can compromise and reduce quality."

The participants in this study blamed management for inadequate resources which complicates the therapeutic care of PWID's. Thus, they recommended more support from the management and supervisors for better therapeutic nursing care delivery.

3.11 Chapter summary

This chapter reported on the thematic analysis of the nominal group discussions held with the registered nurses working in a care-and-rehabilitation facility. The thematic analysis captured seven themes and related sub-themes, describing the registered nurses' recommendations to enhance their therapeutic role. A discussion of the findings entails a literature review, linked to the themes and sub-themes. The final chapter will focus on the summary of research findings, recommendations, limitations and conclusion of the study. It will link it directly to the themes from the discussion, as mentioned above.

CHAPTER 4

Summary of research findings, recommendations, limitations and conclusion of the study

4.1 Introduction

The previous chapter presented a discussion of the research findings. This chapter offers a summary and recommendations based on the research findings as well as some limitations and concluding remarks. The purpose of the study was to explore and describe the recommendations of registered nurses to enhance their therapeutic role in a care-and-rehabilitation facility. To understand the registered nurses' recommendations to enhance their therapeutic role in a care-and-rehabilitation facility, a qualitative, explorative and descriptive research design was used. Data collection was done by means off four nominal group discussions that presented meaningful constructions of participants' recommendations on their therapeutic role. Multiple group data analysis produced seven themes with relevant sub-themes. Recommendations follow the same direction as the thematic data analysis discussed in the previous chapter. The value of the study, personal reflection and conclusion close this chapter.

4.2 Summary of the research findings

The study's findings resulted in seven themes and relevant sub-themes, related to the research question and purpose of this qualitative research. The summary of the themes and sub-themes are as follows:

- The participants felt very strongly about ***communication*** that is critical to enhancing their therapeutic roles in caring for PWID's. They stated that effective *vertical* (management) and *horizontal* (peers and team members) communication could further assist them in providing therapeutic care. It will also improve the *interpersonal relationships* among all staff working in the care-and-rehabilitation facility.

- The participants considered ***staff support*** through a *multidisciplinary approach* as well as *management support* as essential in delivering therapeutic care. They stated that adequate staff support could improve RN's mental wellbeing, contributing to a more positive atmosphere. This would motivate them to provide therapeutic nursing care.
- The participants emphasised a therapeutic **healthcare environment** as a basic need for both PWID's and staff. The participants highlighted areas that need to be improved in the institution such as infrastructure, equipment, as well as the shortage of security personnel for staff and PWID's safety.
- For ***care delivery*** of PWID's, the participants showed the importance of *community and family involvement, rehabilitation and stimulation in activities of daily living* to promote PWID's optimal daily functioning and provide patient-centred care.
- The participants highly recommended ***education*** of the nursing staff working in a care-and-rehabilitation facility. This study revealed that RN's were not prepared to render specialised care to PWID's after completion of their training. Therefore, *orientation and induction, mentorship and skills training* are essential for RN's to deliver competent therapeutic nursing care for PWID's.
- ***Legislative and policy frameworks*** related to health care appeared to be very important for the nurses to understand and apply during the delivery of nursing care. They felt that adherence to *Batho-Pele principles, patients' rights,* as well as *policy and procedures* would help RN's to realise their therapeutic role towards PWID's.
- The participants showed that adequate ***resources,*** including physical and human resources, need to be provided for smooth delivery of health services to meet PWID's needs.

4.3 Recommendations

All recommendations are based on the discussions following the empirical study findings related to these themes and sub-themes. The recommendations will follow the same organisational structure used in chapter 3.

4.3.1 Communication

Recommendations addressing the communication theme include vertical and horizontal communication, as well as interpersonal relationships.

- Managers should conduct monthly goal-directed meetings with the RN's and distribute an agenda before the planned meeting. This will give RN's time to prepare inputs about PWID's nursing care challenges encountered in the wards. Managers should also communicate the meeting's feedback and minutes to all the wards without any delay. Staff needs to be kept updated, ensuring transparency to all (management and staff).
- Establish effective, clear and complete communication platforms (written and oral) to all staff working in a care-and-rehabilitation facility. There should be a commitment from managers to support staff members through effective communication. For example, launch a small steering committee consisting of various nurse categories to explore communication platforms suitable and practical to everyone.
- Investigate the use of information technology for disseminating and accessing information to improve communication. Available and reliable communication technology in each ward would be advisable, replacing the existing communication method. The institution should also give all staff members basic computer training, linked to information and communication practices.
- Appointment of administration clerks is necessary for the wards to assist with patient's administration, relieving RN's from clerical duties rather providing therapeutic nursing care.
- Nursing managers should create opportunities for relationship building, by creating platforms to engage and actively interact with staff members. For example, social gatherings quarterly.
- All managers should attend training courses on communication skills and interpersonal relationship building competencies.

4.3.2 Staff support

A multidisciplinary approach and management support will form part of this theme recommendations.

- Nursing managers should involve health care professionals, namely the social worker, dietician, psychiatrist, psychologist, physiotherapist and occupational therapist in the planning of the multidisciplinary team meetings' year schedule. Involvement in planning might encourage attendance of the multidisciplinary team meetings; fitting their daily routines.
- Managers should be empowered through training**,** sharpen their leadership skills to be transformational and ethical leaders. All nursing managers appointed should have health care management as an additional qualification and undergo refresher in-service training on leadership skills yearly.
- Nursing managers should engage RN's in decisions that affect PWID's care and they should be motivated to make independent clinical decisions. Staff engagement could promote good work relationships, responsibility and participative management.
- As stated by the participants that nursing staff morale is low due to the performance management system (PMS), it requires the implementation of a fair reward system for good performance monitored by the institution. Rewards can also be in the form of individual or ward performance certificates. Additionally, tangible rewards like performance bonuses each year for outstanding staff members delivering above-average therapeutic care, may be ensured.
- Ward managers should take care of the nursing staff's wellbeing by supervising them to identify their physical and psychological status issues pro-actively. Those who need psychological and social assistance, has to be refered to the institution's occupational health clinic Employee Assistance Program (EAP). They must be able to access the social worker, psychologist and psychiatrist services at the workplace. Therefore, the institution's Employee Assistance Program (EAP) needs to be well equipped with active emotional care and support services helping nurses with personal and professional matters that affect their job performance.

- Additional programs, such as stress management and wellness programs, should be established to help RN's to cope with their personal, physical and work-related stressors. Stress management training and wellness programs should involve the occupational health nurse for screening, a dietician to promote proper nutrition, as well as the occupational therapist and physiotherapist for the nurses' physical fitness. Establishing sports activities on a weekly basis, such as fun walks and exercises, could be beneficial for nurses' wellbeing.
- The researcher suggests that managers should offer nursing staff a four weeks or two weeks cycle of leave annually. This need to be in between a year's leave plan for them to take a break. In addition to annual leave, the nursing staff needs to be rotated regularly. For example, changes need to happen every 6-12 months between heavy (immobile) and light (mobile) wards; and for severe and profound PWID's.

4.3.3 Healthcare environment

The environment where PWID's receive care need restructuring to provide support, maintain safety, comfort and human dignity.

- Encourage the wards to create a stimulating therapeutic environment for PWID's. Establish effective day and stimulation programs for all staff members to follow as part of nursing care delivery.

- Safety issues should be a priority for PWID's and staff in a care-and-rehabilitation facility. The existing health and safety committee in the institution should be more active, with well-trained representatives to regularly perform clinical risk assessments in the wards. They need to make recommendations for the development of quality improvement projects. Monitoring and evaluation of quality improvement projects related to infrastructure on a monthly basis would ensure compliance with safety measures.

- Empowerment of nurses on safety issues are necessary to build their confidence when handling PWID's and reduce the risks. A safety program is essential to

train nurses about workplace hazards and safety procedures to follow. Such training should include the use of personal protective equipment.

- Reporting PWID's incidents should be a supportive and non-judgmental system to reduce unreported incidents. Reporting patients' incidents to maintain trust between the institutions, patient's families and health care professionals (Walsh, 2016:81-82).
- Allocation of security personnel in the facility near the wards to be visible, maintaining a safe environment for PWID's and staff. RN's also mentioned that PWID's move out of the wards. There is a need for CCTV cameras to lessen the burden of care and assist staff with supervision of PWID's that tend to wander or abscond.

4.3.4 Care delivery

Recommendations on care delivery will discuss community and family involvement, rehabilitation and stimulation in activities of daily living.

- The social worker should trace the family and encourage them to come for a visit or take PWID's home for weekends. This would promote PWID's interaction with the family members, preventing a feeling of loneliness and restlessness. RN's should use the opportunity when a family visits to supply them with information and teach them skills to manage PWID's.
- Community awareness campaigns about PWID's could also help to minimise the stigma attached. One example is open days during mental health awareness month at FSPC where the media, public and families are invited. Then engage in different activities, providing information, education and support. PWID's having minimal or no physical disabilities will get the opportunity to participate and interact with people.
- A care-and-rehabilitation facility should change from the traditional patient care practices and adopt a patient-centred care approach. PCC would be beneficial to increase the RN's level of engagement and provide individualised care of PWID's. Conduct a situational analysis regarding PCC principles and then plan the gradual implementation of PCC accordingly. After that, formulate a PCC

policy for care-and-rehabilitation wards and provide relevant training for the nursing staff on PCC principles. The institution may appoint a task team to follow-up PCC implementation in the wards.

- RN's need retraining, mentoring and support to initiate and maintain stimulation program for PWID's. They need to work together with the occupational and physiotherapists in each ward. Communicate planned stimulation goals for PWID's to all levels of the nursing staff, ensuring continuity. Re-evaluate these goals monthly and adapt it relating to the changing needs of the PWID's.
- Each ward should receive a lockable toolbox or container made by the institution's workshop. This toolbox should consist of stimulation equipment relevant to the PWID's needs and abilities. It should be relevant to the specific ward.
- Recruitment of more physiotherapists and occupational therapists, considering the capacity of PWID's in a care-and-rehabilitation facility, will be of advantage for them to receive special attention. The occupational or physiotherapist will evaluate PWID's and develop their programs. Nurses will implement and maintain these programs

4.3.5 Education

Educational recommendations focus on orientation and induction of staff, mentorship and skills training.

- A structured orientation and induction program is essential to prepare RN's to adjust for an institution for care, treatment and rehabilitation of PWID's. It should help to transform newly appointed graduates to RN's. Orientation programs develop the confidence and competence of new nurse graduates to perform their tasks (Lindfors & Junttila, 2014:2-14). Managers should revise the institutional orientation and induction policy for new staff members. The new staff members should follow a specific program that indicates the duration of the orientation, with specific outcomes to complete and a mentor assigned to them. After that, evaluations on RN's performance in the wards, after a set period, should be conducted.

- Establish a mentoring program by selecting experienced senior RN's and train them on how to be a mentor. This should be integrated in the orientation and induction program. Then implement a mentoring program for three months after a new staff member underwent the orientation and induction program. There should be a mentor appointed for each new staff member.
- Managers should attend training courses on leadership and mentoring, enabling them to gain skills and abilities to perform mentoring duties with a positive impact.
- RN's should receive continuous training and support on therapeutic nursing skills, considering factors related to the PWID's level of functioning.
- The researcher proposes a proper assessment of the nursing staff's training needs by the managers and training coordinator or facilitator in the wards. There should be a year plan for the in-service training program, whereby registered nurses collaborate with the managers on practical topics relevant to their training needs.
- Planning for attendance of in-service training programs should be in such a way that most nurses can attend. This should be rewarded with concrete rewards.
- Training methods should be appropriate for adult education, applying problem-solving approaches and adult training principles to engage RN's to be active participants. This will help to gain effective learning, giving solutions to the problems encountered in the wards during PWID's care. To improve RN's caring for PWID's ability and confidence in their clinical practice, the institution can adopt evidence-based simulation training.
- Establish an in-service training committee by appointing more clinical training facilitators to offer training on stimulation activities, therapeutic nursing care and the latest nursing care activities for PWID's. This needs to be done in accordance with the year program linked to RN's needs.
- Develop assessment strategies to evaluate the effectiveness of the training given. Monitor and evaluate the performance of the nurses in the wards to identify their training needs, as well as improve the planning and implementation

of the training program. Link in-service training program attendance with the achievement of certain performance outcomes, Successful completion thereof may be rewarded with a certificate. The best candidate may receive a floating trophy. This may become a quarterly event.

- The institution should collaborate with the local nursing education institutions, such as colleges and universities to offer refresher courses, workshops and symposiums. The training institutions could provide short courses on intellectual disability care and mental health. Later on, these courses may be formalized as ongoing professional development for RN's. Partnership with the universities might include access to training resources, such as nursing journals, textbooks with recent information and experts (Letlape *et al*., 2014:1-9). All of this may improve PWID's care.
- Management should advise the Free State Department of Health, Higher Education Institutions and the South African Nursing Council on the crucial need in mental health care training among RN's. SANC could be requested to urgently accredit the University of the Free State to offer advanced mental health care qualifications or specialist mental health training instead of funding RN's to study with institutions outside the province. Presently attending training by other universities outside the Free State province that offer psychiatric training for RN's, imply high costs to the Department of Health.
- A skills development committee should review the institution's training policy to provide more study leave for RN's to further their studies. Nurses often wait for a long period before getting approval for study leave. The delay to train nurses result in study leave many a time offered to nurses approaching their retirement age. On completion of training, they then have already reached retirement age and the institution loses qualified expert nurses.

4.3.6 Legislative and policy framework

The Batho-Pele principles, the Patient's Rights Charter, as well as policy and procedures formed part of these theme's recommendations.

- The managers should emphasise health care legal frameworks during service delivery to PWID's and incorporate this in the nurses' code of conduct for effective application.
- There should be a "zero tolerance" standard toward patient abuse. Managers should create a culture of accountability by not tolerating or ignoring abusive behaviour reported by staff members. Managers should act as role models and change agents by showing that abusive practices are not allowed. They should rather motivate staff members to care. This could counter the perception that institutional care attributes towards patient abuse.
- Nursing managers should make nurses aware of the policy that protects them when exposing unethical practices towards PWID's. The managers should show support and encourage responsible nursing staff to report unethical behaviour,without being mistreated. This will encourage reporting of unethical practices and protect PWID's rights. Training must be provided for the reinforcement of work ethics and proper disciplinary measures should be in place to minimise unprofessional conduct.
- The institution policies and procedures should be available. Managers have to review them regularly and be specific with regard to the care of PWID's.
- Consultation and training of RN's are necessary to promote participation in the development of the new policies. Involvement of RN's in policymaking processes might empower them to be proactive leaders.

4.3.7 Resources

Recommended ideas for resources entail physical and human resources.

- Effective and efficient utilisation of material resources needs monitoring and control by the managers in the wards to prevent misuse and damage. Hence, training of staff to operate new medical equipment and proper care will be beneficial to ensure sustainability.
- Management should have a procurement and maintenance plan in place for physical equipment. Regular servicing of equipment will ensure their functionality and reduce replacement costs.

- A reporting system should be created of non-functioning medical equipment to help it to be repaired immediately. The institution should ensure that the technical workshop is equipped with skilled staff and tools for the prompt repair of general equipment. A technical workshop can also help to design PWID's special equipment for activities of daily living. For example, spoons may be adjusted for those patients with contractures.
- The institution should provide adequate food, seasonal clothing and linen for PWID's. This is a basic need and forms part of their therapeutic care. Management should address laundry issues that contribute to a shortage of patients' clothing and linen. A system should be put in place for ordering, distribution and monitoring patients. clothes and linen**.**
- Nursing managers should revise the nursing staffing levels in the wards according to nurse-patient ratios, as well as the skills mix for special needs of PWID's. RN's allocation should consider each ward's bed capacity and PWID's functioning levels.
- Review the institution recruitment strategies by analysing the nursing staff turnover to plan. The institution needs a dynamic strategic plan to retain staff members and an active marketing campaign to recruit young professionals. For example, retain community professional nurses in the system after the completion of their contract. This will only be possible if there is a positive working climate with supportive managers.

4.4 Limitations of the study

The study had some limitations to be noted. Providing a description of the therapeutic role to the participants during NGD's may have influenced the open-endedness and co-construction of knowledge. Secondly, although the researcher managed to hold four nominal group discussions comprising of 22 registered nurses, from one care-and rehabilitation facility, the unavailability of some RN's due to other responsibilities that day, resulted in a reduced number of participants. Thirdly, the study's inclusion criteria excluded other nursing categories working in the care-and-rehabilitation facility, limiting representation of lower nurse categories' recommendations. This could be kept in mind for future research studies. Inclusion criteria also excluded RN's working less than

three months. Due to NGD's held during the day, it resulted in the inability of a bigger sample. If that was not the case it could perhaps cause the collection of more information-rich data. Lastly, the study findings apply to the care-and-rehabilitation facility at the FSPC hospital, restricting the generalisability thereof.

4.5 Value of the study

The researcher used NGT discussions to explore and describe the RN's recommended ideas to enhance their therapeutic role in a care-and-rehabilitation facility. The NGT allowed the RN's to share their ideas, as well as learn and empower each other during the engagement process. It also allowed the RN's to reflect on the importance of therapeutic skills and nursing care by creating awareness of the therapeutic roles of nurses. The study findings could further provide a platform to RN's to look into continuous professional development and self-directed learning activities**.** Furthermore, this could add value to the attitude of care when RN's reflect on their ideas to improve their therapeutic actions to a vulnerable group of patients. The study's findings may be valuable to various stakeholders, namely the FSPC hospital management as well as the Free State Department of Health.

4.6 Researcher's reflection of the research process

This section relates to the researcher's experiences, challenges and perceptions regarding the study. The researcher started conducting the research project, having the background and theoretical knowledge, but she still doubted her own abilities. The research proposal was the beginning of a learning curve in applying academic writing. It was an overwhelming experience to embark on this new project, recruiting participants, and preparing for nominal group discussion meetings. Moreover, a stressful moment was on the day of the group discussions. The researcher was waiting for the participants to attend the discussions and was not sure, whether they will manage to come despite all the preparations made.

From chapter 1 to chapter 4 was a learning adventure. Chapter 2 gave the researcher a deep understanding of what the research is all about, including the language used. Data analysis was very challenging. A new technique had to be learned as well as how

to apply Van Breda's steps analysing multiple NGT. Data had to be captured in a specific way on the computer, all the calculations had to be done and different tables created. A lot of time was spent on capturing substantial amounts of data from the flip-charts onto the computer and ensuring that the calculations were correct. The process of data analysis required critical thinking skills by interpreting and managing the data collected. Although chapter 3 was very interesting, one immerses the self very easily and has to guard to remain rational in reporting the study findings. In Chapter 4, the researcher became comfortable, leading to recommendations reflecting on the study findings.

Personally, the researcher struggled to balance her time as a worker, parent and student. However, the whole process was very fulfilling academically to see the end of the work. Perseverance and discipline carried her through this process with all the challenges encountered during the studies.

4.7 Conclusion

Chapter 4 concluded with a summary of the study findings, researcher's recommendations, limitations, the value of the study as well as a reflection about the research process. This explorative, descriptive and qualitative study allowed the researcher to explore and describe registered nurses' recommendations enhancing their therapeutic role in a care-and-rehabilitation facility. Through the NGT, the researcher could actively collect data from applicable participants as written in chapter 1.

This study's findings illuminated the complex nature and crucial importance of therapeutic care for PWID's, especially by registered nurses in care-and-rehabilitation wards. RN's are these patients' only "advocates" in an environment representing "a home" away from home or even no home. With such a responsibility, the RN's should be able to deliver therapeutic care providing the necessary caring practices enabling a therapeutic milieu for the most vulnerable.

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ANNEXURES

ANNEXURE A: PERMISSION LETTERS

ANNEXURE B: INVITATION TO PARTICIPATE IN THE STUDY

ANNEXURE C: CONSENT FORM

ANNEXURE D: APPROVAL LETTTERS

FREE STATE DEPARTMENT OF HEALTH LETTER

THE INSTITUTION LETTER

HEALTH SCIENCES RESEACH ETHICS COMMITTEE (HSREC) LETTER

ANNEXURE E: NGT DATA TOP 5 STATEMENTS

ANNEXURE A

PERMISSION LETTERS

Mofokeng Anna.N

P.O. Box 4064

Bloemfontein

9300

Health Sciences Research Ethics Committee

Sir/Madam

I am a student at the University of Free State pursuing my Master's degree in Nursing Science (M.Soc.Sc) and currently work at Free State Psychiatric Complex. My research study title is: **ENHANCING THE THERAPEUTIC ROLE OF REGISTERED NURSES IN CARE AND REHABILITAION FACILITY.**

The purpose of the research study is to explore and describe the registered nurses recommendations to enhance their therapeutic role in Care-and-rehabilitationfacility.

I am asking for permission to conduct this study at Free State Psychiatric Complex and gather data from the registered nurse.

See the attached research proposal and approval from the University of Free State Health Science Research Ethics Committee.

I will appreciate if permission can be granted to conduct this research study.

Ntoki Anna Mofokeng

M.Soc.Sc student FSPC Hospital

Mofokeng Anna.N

P.O. Box 4064

Bloemfontein

9300

Free State Department of Health

Sir/Madam

I am a student at the University of Free State pursuing my Master's degree in Nursing Science (M.Soc.Sc) and currently working at Free State Psychiatric Complex. My research study title is: **ENHANCING THE THERAPEUTIC ROLE OF REGISTERED NURSES IN CARE-AND-REHABILITATIONFACILITY.**

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See the attached research proposal and approval from the University of Free State Health Science Research Ethics Committee.

I will appreciate if permission can be granted to conduct this research study.

Ntoki Anna Mofokeng

M.Soc.Sc student FSPC Hospital

Mofokeng Anna. N

P.O. Box 4064

Bloemfontein

9300

Free State Psychiatric Complex

Manager

Free State Health Science Research Ethics Committee.

I will appreciate if permission can be granted to conduct this research I am a student at the University of Free State pursuing my Master's degree in Nursing Science (M.Soc.Sc) and currently working at Free State Psychiatric Complex. My research study title is: **ENHANCING THE THERAPEUTIC ROLE OF REGISTERED NURSES IN CARE AND REHABILITAION FACILITY.**

The purpose of the research study is to explore and describe the registered nurses recommendations to enhance their therapeutic role in Care-and-rehabilitationfacility.

I am asking for permission to conduct this study at Free State Psychiatric Complex and gather data from the registered nurse.

See the attached research proposal and approval from the University of Free study.

Ntoki Anna Mofokeng
M.Soc.Sc student FSPC Hospital

ANNEXURE B

INVITATION LETTER FOR PARTICIPANTS

Mofokeng Anna. N

P.O. Box 4064

Bloemfontein

You are hereby invited to participate in the research study to be conducted at your work place for 1-2 hours group discussion.

ENHANCING THE THERAPEUTIC ROLE OF REGISTERED NURSES IN CARE-AND-REHABILITATION FACILITY

Purpose: To explore and describe the registered nurses recommendations to enhance their therapeutic role in care-and-rehabilitation facility.

Your participation is voluntary; no one is forced to participate. You can decide to withdraw from participating at any time without any penalty. No remuneration available for participating in the study.

Confidentiality: The information you give will be handled confidentially no personal information will be disclosed. Your information can be used to make recommendation to the institution.

Risks and benefits: There is no risk involved for participating in the study. Registered nurses will be given a chance to raise their ideas to enhance their therapeutic role in care-and-rehabilitation facility.

For more information or questions contact the researcher. Contact details:

Mofokeng Anna N, Cell phone number: 0762966401, Email: namofoke@gmail.com

ANNEXURE C

CONSENT FORM

STUDY TITLE: ENHANCING THE THERAPEUTIC ROLE OF REGISTERD NURSES IN CARE-AND-REHABILITATIONFACILITY

You are hereby invited to participate in the research study, whereby a group discussion meeting will be held to generate recommendations to enhance the therapeutic role of the registered nurses in care-and-rehabilitation facility at Free State Psychiatric Complex.

You have been informed about the study by Anna Mofokeng. You may contact me at 076 2966401 / namofoke@gmail.com any time if you have questions about the research.

You may contact the Secretariat of the Health Science Research Ethics Committee of the Faculty of Health Sciences, UFS at telephone number (051) 4052812 if you have questions about your rights as a research participant.

Your participation in this research is voluntary, and you will not be penalized or lose benefits if you refuse to participate or decide to terminate participation. No costs to you will result from participating in the study and there is no remuneration for participating

If you agree to participate, you will be given a signed copy of this document as well as the participant information sheet, which is a written summary of the research.

The research study, including the above information has been verbally described to me. I understand what my involvement in the study means and I voluntarily agree to participate.

_____ _____

Signature of Participant Date

_____ _____

Signature of Witness Date

ANNEXURE D

APPROVAL LETTERS

1. FREE STATE DEPARTMENT OF HEALTH LETTER
2. THE INSTITUTION LETTER
3. HEALTH SCIENCES RESEACH ETHICS COMMITTEE (HSREC) LETTER

health

Department of
Health
FREE STATE PROVINCE

14 June 2017

Ms. NA Mofokeng
C/O Ms. R Jansen
School of Nursing
Idalia Loots Nursing
UFS

Dear Ms. NA Mofokeng

Subject: Enhancing the therapeutic role of registered nurses in a care and rehabilitation facility

- Please ensure that you read the whole document, Permission is hereby granted for the above – mentioned research on the following conditions:
- Participation in the study must be voluntary.
- A written consent by each participant must be obtained.
- Serious Adverse events to be reported to the Free State department of health and/ or termination of the study
- Ascertain that your data collection exercise neither interferes with the day to day running of the Free State Psychiatric Complex nor the performance of duties by the respondents or health care workers.
- Confidentiality of information will be ensured and please do not obtain information regarding the identity of the participants.
- Research results and a complete report should be made available to the Free State Department of Health on completion of the study (a hard copy plus a soft copy).
- Progress report must be presented not later than one year after approval of the project to the Ethics Committee of the University of Free State and to Free State Department of Health.
- Any amendments, extension or other modifications to the protocol or investigators must be submitted to the Ethics Committee of the University of Free State and to Free State Department of Health.
- **Conditions stated in your Ethical Approval letter should be adhered to and a final copy of the Ethics Clearance Certificate should be submitted to** sebeelats@fshealth.gov.za **before you commence with the study**
- No financial liability will be placed on the Free State Department of Health
- Please discuss your study with the institution manager/CEOs on commencement for logistical arrangements
- Department of Health to be fully indemnified from any harm that participants and staff experiences in the study
- Researchers will be required to enter in to a formal agreement with the Free State department of health regulating and formalizing the research relationship (document will follow)
- You are encouraged to present your study findings/results at the Free State Provincial health research day
- Future research will only be granted permission if correct procedures are followed see http://nhrd.hst.org.za

Trust you find the above in order.
Kind Regards

Dr D Motau
HEAD: HEALTH
Date: 20/06/17

Head : Health
PO Box 227, Bloemfotein, 9300
4th Floor, Executive Suite, Bophelo House, cnr Maitland and, Harvey Road, Bloemfotein
Tel: (051) 408 1646 Fax: (051) 408 1556 e-mail:khusemj@fshealth.gov.za@fshealth.gov.za/chikobvup@fshealth.gov.za

free state psychiatric complex

Department of Health
Free State Psychiatric Complex
FREE STATE PROVINCE

26TH June 2017

UNIVERSITY OF THE FREE STATE
UNIVERSITEIT VAN DIE VRYSTAAT
YUNIVESITHI YA FREISTATA

UFS·UV
HEALTH SCIENCES
GESONDHEIDSWETENSKAPPE

IRB nr 00006240
REC Reference nr 230408-011
IORG0005187
FWA00012784

19 July 2017

MS NA MOFOKENG
C/O MS R JANSEN
SCHOOL OF NURSING
IDALIA LOOTS BUILDING
UFS

Dear Ms Mofokeng

HSREC 44/2017 (UFS-HSD2017/0301)
PRINCIPAL INVESTIGATOR: MOFOKENG, NTOKI
SUPERVISOR: RONELLE JANSEN, SCHOOL OF NURSING
PROJECT TITLE: ENHANCING THE THERAPEUTIC ROLE OF REGISTERED NURSES IN A CARE AND REHABILITATION FACILITY

1. You are hereby kindly informed that the Health Sciences Research Ethics Committee (HSREC) approved this protocol after all conditions were met. This decision will be ratified at the next meeting to be held on 25 July 2017.

2. The Committee must be informed of any serious adverse event and/or termination of the study.

3. Any amendment, extension or other modifications to the protocol must be submitted to the HSREC for approval.

4. A progress report should be submitted within one year of approval and annually for long term studies.

5. A final report should be submitted at the completion of the study.

6. Kindly use the **HSREC NR** as reference in correspondence to the HSREC Secretariat.

7. The HSREC functions in compliance with, but not limited to, the following documents and guidelines: The SA National Health Act. No. 61 of 2003; Ethics in Health Research: Principles, Structures and Processes (2015); SA GCP(2006); Declaration of Helsinki; The Belmont Report; The US Office of Human Research Protections 45 CFR 461 (for non-exempt research with human participants conducted or supported by the US Department of Health and Human Services- (HHS), 21 CFR 50, 21 CFR 56; CIOMS; ICH-GCP-E6 Sections 1-4; The International Conference on Harmonization and Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH Tripartite), Guidelines of the SA Medicines Control Council as well as Laws and Regulations with regard to the Control of Medicines, Constitution of the HSREC of the Faculty of Health Sciences.

Yours faithfully

.....
DR SM LE GRANGE
CHAIR: HEALTH SCIENCES RESEARCH ETHICS COMMITTEE

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ANNEXURE E

NGD TOP 5 STATEMENTS

All THE STATEMENTS FROM ALL 4 GROUPS & TOP 5/GROUP

GROUP	THEME	SUB-THEME	STATEMENT	SCORES	AVERAGE	TOP5
1	**1.LEGISLATIVE AND POLICY FRAMEWORK**	1.3 Policy and procedures	**1.**Institutional policies and procedures	4,5,4,1	1.75 (**3**)	**X**
1	**1.LEGISLATIVE AND POLICY FRAMEWORK**	1.3 Policy and procedures	**7.**Mental Health Act adherence	5,5	1.25 **(5)**	**X**
1	**1.LEGISLATIVE AND POLICY FRAMEWORK**	1.2 Patients' rights	**24.**Maintan privacy and confidentiality	5,5	1.25 **(5)**	**X**
2	**1.LEGISLATIVE AND POLICY FRAMEWORK**	1.3 Policy and procedures	**5**.Delegation of duties(scope of practice)	2,5	1.4 **(3)**	**X**
2	**1.LEGISLATIVE AND POLICY FRAMEWORK**	1.2 Patients' rights	**8**.Advocate for patients	2,3	1 (**5)**	**X**
2	**1.LEGISLATIVE AND POLICY FRAMEWORK**	1.3 Policy and procedure	**5**.Delegation of duties(scope of practice)	2,5	1.4 **(3)**	**X**
4	**1.LEGISLATIVE AND POLICY FRAMEWORK**	1.1 Batho- Pele principles	**10.**Batho Pele principles adherence	3,4	1.75 **(3)**	**X**
4	**1.LEGISLATIVE AND POLICY FRAMEWORK**	1.3 Policy and procedures	**15.**Leave planning	3,3	1.5 **(4)**	**X**

4	**1.LEGISLATIVE AND POLICY FRAMEWORK**	1.3 Policy and procedures	**16**.Apply procedure and guidelines	3,4	1.75 **(3)**	**X**
1	**2. RESOURCES**	2.1 Physical resources	5.Availabilty medication/ treatment	**5,5**	**1.25 (**5)	X
2	**2.RESOURCES**	2.2 Human Resources	**2.**Increase Human resource (patient -staff ratio)	2,5	1.4 (**3)**	**X**
2	**2.RESOURCES**	2.1 Physical resources	**16**.Infrastructure improvement	4,4,5	2.6 (**2)**	**X**
3	**2.RESOURCES**	2.1 Physical resources	2.Equipment's availability	4,2	1.2 (**4)**	**X**
3	**2.RESOURCES**	2.2 Human resources	4.Personnel shortage	1,5,3,4	2.6 (**2)**	**X**
4	**2.RESOURCES**	2.2 Human resources	**7.**Staffing-personnel in the wards	2,4,4	2.5 **(2)**	**X**
4	**2.RESOURCES**	**2**.1 Physical resources	**8.** Available material resources	3,2	1.25 **(5)**	**X**
4	**2.RESOURCES**	2.1 Physical resources	**11.**Revitilisation –infrastructure	3,2	1.25 **(5)**	**X**
4	**3.HEALTHCARE ENVIRONMENT**	3.1 Safety	**1.**Safe environment for patients and staff	5,5,5,5	5 **(1)**	**X**
1	**4.CARE DELIVERY**	4.1 Rehabilitation	**2.**Rehabilitation	5,2,4,5	2 (**2)**	**X**

1	**4.CARE DELIVERY**	4.1 Rehabilitation	**2.**Rehabilitation	5,2,4,5	2 (**2)**	**X**
1	**4.CARE DELIVERY**	4.3 Activities of daily living	**9**. Focus on activities of daily living improvement	5,2,4,5	2 (**2)**	**X**
2	**4.CARE DELIVERY**	4.4 Family and community involvement	**6**.Posters for information Intellectual disability(family)	4,5,3,1,5	3.6 **(1)**	**X**
3	**4.CARE DELIVERY**	4.2 Stimulation program	3.Activities for patients	5	1 (**5)**	X
3	**4.CARE DELIVERY**	4.4 Family and community involvement	**7.**Family involvement	3,2,1	1.2 **(4)**	**X**
1	**5.EDUCATION**	5.1 Skills training	**15.**Skills development	4,5,5,4	2.25 **(1)**	**X**
2	**5.EDUCATION**	5.3 Mentorship	**7.**Mentor new staff	2,5	1.4 **(3)**	**X**
2	**5.EDUCATION**	5.2 Orientation and induction	**11**.Orientation and induction of new staff	2,5	1.4 (**3)**	**X**
2	**5.EDUCATION**	5.1 Skills training	**17**.Opportunity for self-development	2,5	1.4 (**3)**	**X**
2	**5.EDUCATION**	5.1 Skills training	**18**.Inservice trainings for nurses	2,5	1.4 **(3)**	**X**

3	**5.EDUCATION**	5.1 Skills training	**1.**Training of nurses	4,2,5,5	3.2 (**1)**	**X**
4	**5.EDUCATION**	5.2 Orientation and induction	**2**.Orientation of new staff	3,3	1.5 **(4)**	**X**
1	**6.COMMUNICATION**	6.2 Vertical and horizontal communication	**4.**Enhance communication	1,3,1,4,1,2	1.5 (**4)**	**X**
2	**6.COMMUNICATION**	6.1 Interpersonal relationships	**10.**Good interpersonal relationships	2,5	1.4 (**3)**	**X**
1	**7.STAFF SUPPORT**	7.2Management	**11**. Management support	1,3,1,4,1,2	1.5 **(4)**	**X**
1	**7.STAFF SUPPORT**	7.2Management	**20.**Staff support	1,3,1,4,1,2	1.5 **(4)**	**X**
2	**7.STAFF SUPPORT**	7.2 Management	**14.**Participative management for visible leadership	3,1,5,4	2.6 (**2)**	**X**
3	**7.STAFF SUPPORT**	7.1 Multidisciplinary approach	5.Complete multidisciplinary team	3,1,2	1,2 (**4)**	**X**
3	**7.STAFF SUPPORT**	7.2 Management	6.Motivation of personnel	3,1,4	1.6 (**3)**	**X**

All 4 NGD groups' participant's statements (raw data)

GROUP 1 n=8	THEME	STATEMENT	SCORES	T0TAL SCORE / MEMBERS = AVERAGE	TOP5
1		1.Institutional policies and procedures(apply)	4,5,4,1	14/8 = 1.75	
1		2.Rehabilitation	5,2,4,5	16/8 =2	
1		3.Safe environment	4,3	7/8 =0.875	
1		4.Enhance communication	1,3,1,4,1,2	12/8 = 1.5	
1		5.Availability of treatment(medication)	5,5	10/8 = 1.25	
1		6.Discharge support	3,2	5/8 = 0.625	
1		7.Mental Health Act adherence	5,5	10/8 =1.25	

1		8.Social interaction	3,2	5/8 =0.625	
1		9. Focus on activities of daily living improvement	5,2,4,5	16/8 = 2	
1		10. Stimulation activity or program	3	3/8 = 0.375	
1		11. Management support	1,3,1,4,1, 2	12/8 =1.5	
1		12.Corect staff patient ratio reduce workload	2,1	3/8 = 0.375	
1		13. Love and support for staff and patients	3,5	8/8 =1	
1		14.Community involvement	3	3/8 = 0.375	
1		15.Skills development	4,5,5,4	18/8 =2.25	

GROUP 1 n=8	THEME	STATEMENT	SCORES	TOTAL SCORE/ MEMBERS = AVERAGE	TOP5
1		16.Placement of staff	2,1	3/8 =0.375	
		17.Availability of equipment's	4,3	7/8 = 0.875	
1		18.Proper clothing	2,3,2	7/8 = 0.875	
		19.Safe and clean environment	4,3	7/8 = 0.875	
1		20.Staff support	1,3,1,4,1,2	12/8 =1.5	

1		21.Patient advocacy	2	2/8 =0.25	
1		22.Use of Technology	2,3,2	7/8 = 0.875	
1		23.Debriefing for staff	3,1,1	5/8= 0.625	
1		24.Maintains privacy and confidentiality	5,5	10/8 =1.25	

Group 2 participant's statements

GROUP 2 n=5	THEME	STATEMENT	SCORES	TOTAL SCORE /MEMBERS =AVERAGE	TOP5
2		1.Available material resources	4,5,3,1,5	18/5=3.6	
2		2.Available Human Resource	2,5	7/5 =1.4	
2		3.Understanding challenges of intellectual disability	1	1/5= 0.2	
2		4.Family involvement	1	1/5 =0.2	

2		5.Delegation of duties(scope of practice)	2,5	7/5 =1.4	
2		6.Inservice training for nurses	2,5	7/5 =1.4	
2		7.Posters for information intellectual disability(family)	2,5	7/5 =1.4	
2		8. Time spend for patient	3	3/5 =0.6	
2		9.Mentor new staff	2,5	7/5 =1.4	
2		10.Advocate for patients	2,3	5/5 =1	

2		11.Group activities for wellbeing of patient	3	3/5 =0.6	
GROUP 2 n=5	THEME	STATEMENT	SCORES	TOTAL SCORE/ MEMBER =AVERAGE	TOP 5
2		12. 0rientatiion an induction	2,5	7/5 =1.4	
2		13.Role of multidisciplinary team	2,2	4/5 =0.8	
2		14.Consider policies and procedures	4,2	6/5 =1.2	
2		15.Participative management or visible leadership	3,1,5,4	13/5 =2.6	
2		16.Good interpersonal			

		relationships	2,5	7/5 =1.4	
2		17.Self-development opportunities	2,5	7/5 =1.4	
2		18.Communication be clear and precise	3,1	4/5 =0.8	
2		19.Labour relations measures implemented(disciplinary)	2,5	7/5 =1.4	

Group 3 participant's statements

GROUP 3 n=5	THEME	STATEMENT	SCORES	TOTAL SCORE /MEMBER =AVERAGE	TOP5
3		1.Training nurses mental health	4,2,5,5	16/5= 3.2	
3		2.Available safe equipment	4,2	6/5 = 1.2	
3		3.Activities for patients	5	5/5 = 1	
3		4. Personnel shortage addressed	1,5,3,4	13/5 =2.6	
3		5.Complete multi-disciplinary team	3,1,2	6/5 = 1.2	

3		6. Family involvement	3,2,1	6/5 = 1.2	
3		7. Activities for patients	5	5/5 =1	5

Group 4 participant's statements

GROUP n=4	THEME	STATEMENT	SCORES	TOTAL SCORE/ MEMBER =AVERAGE	TOP5
4		1.Safe environment-patients and personnel	5,5,5,5	20/4=5	
4		2.Orientation	3,3	6/4 =1.5	
4		3.Training and development	2	2/4 =0.5	
4		4.Transparecy and communication	2,1	3/4 =0.75	
4		5.Favouritism	2,1	3/4 =0.75	
4		6.Leave	3,3	6/4 =1.5	
4		7. On-going assessment of care users capabilities	4	4/4 =1	

4		8. Procedures and guidelines and Batho - Pele Principles	3,4	7/4 =1.75	
4		9. Staffing	2,4,4	12/4 =3	
4		10. Material resources and Revitalisation	3,2	6/4 = 1.5	
GROUP n=4	THEME	STATEMENT	SCORES	TOTAL SCORE/ MEMBER = AVERAGE	TOP5
4		11.Multidisciplinary approach	1,1,1	3/4 =0.75	
4		12.Victimisation	2,1	3/4=0.75	
4					

		13.Support visits	2.1	3/4=0.75	
4		14.Avoid favouritism	2,1	3/4=0,75	
4		15.Leave planning	3,3	6/4=1.5	
4		16.Apply procedure and guidelines	3,4	7/4=1.75	

Top 5 statements group 1-4

Group 1 Top 5

GROUP 1 n=8	THEME	STATEMENT	SCORES	T0TAL SCORE/ MEMBER= AVERAGE	PRIORITY	TOP5
1		1.Skills development	4,5,5,4	18/8 = 2.25	1	X
		2.Rehabilitation	5,2,4,5	16/8 = 2	2	x
1		3. Focus on activities of daily living improvement	5,2,4,5	16/8 = 2	2	X
1		4.Institutional policies and procedures(apply)	4,5,4,1	14/8 = 1.75	3	X
1		5.Enhance communication	1,3,1,4,1,2	12/8 = 1.5	4	X

1		6. Management support	1,3,1,4,1, 2	12/8 =1.5	4	X
1		7.Staff support	1,3,1,4,1, 2	12/8 = 1.5	4	X
1		8.Availability of treatment(medication)	5,5	10/8 = 1.25	5	X
1		9.Mental Health Act adherence	5,5	10 /8 = 1.25	5	X
1		10.Maitain privacy and confidentiality	5,5	10/8 = 1.25	5	X

Group 2 Top 5

GROUP2 N=5	THEME	STATEMENT	SCORES	TOTAL SCORE/ MEMBER = AVERAGE	PRIORITY	TOP5
2		1.Available material Resource	4,5,3,1,5	18/5=3.6	1	X
2		2.Posters for information(family)	4,5,3,1,5	18/5 =3.6	1	X
2		3.Participative management or visible leadership	3,1,5,4	13/5 =2.6	2	X
2		4.Proper infrastructure	4,4,5	13/5 =2.6	2	X
2		5.Delegation of duties(scope				

		of practice)	2,5	7/5 =1.4	3	X
2		6.Inservice training	2,5	7/5 =1.4	3	X
2		7.Labour relations measures implemented(disciplinary)	2,5	7/5 =1.4	3	X
2		8.Mentor new staff	2,5	7/5 =1.4	3	X
2		9.Increase Human Resource(patient -staff ratio)	2,5	7/5 =1.4	3	X
2		10. 0rientation an induction	2,5	7/5 =1.4	3	X

Group 3 Top 5

GROUP 3 n=5	THEME	STATENENT	SCORE	TOTAL SCORE/ MEMBER= AVERAGE	PRIORITY	TOP5
3		1.Training of nurses	4,2,5,5	16/5 =3.2	1	X
3		2.Personnel shortage to be addressed	1,5,3,4	13/5 =2.6	2	X
3		3.Motivation of staff	3.1,4,	8/5 =1.6	3	X
3		4.Available safe equipment	4,2	6/5 =1.2	4	X
3		5.Complete multi-disciplinary team	3,1,2	6/5 =1.2	4	X

3		6. Family involvement	3,2,1	6/5 =1.2	4	X
3		7. Activities for patients	5	5/5 =1	5	X

Group 4 Top 5

GROUP n=4	THEME	STATEMENT	SCORES	TOTAL SCORE /MEMBER =AVERAGE	PRIORITY	TOP 5
4		**1.**Safe environment	5,5,5,5	20/4=5	**1**	**X**
4		**7.**Staffing wards	2,4,4	10/4=2.5	**2**	**X**
4		**10.**Batho Pele principles adherence	3,4	7/4=1.75	**3**	**X**
4		**2**.Orientate new staff	3,3	6/4=1.5	**4**	**X**
4		**15.**Leave planning	3,3	6/4=1.5	**4**	**X**
4		**8.** Available, safe material resources	3,2	5/4=1.25	**5**	**X**
4					**5**	**X**

		11. Revitilisation infrastructure	3,2	5/4=1.25		
4		**16.**Apply procedure and guidelines	3,2	5/4=1.25	**5**	**X**