

**AN EXPLORATION
OF STAKEHOLDERS PERCEPTIONS OF THE ADVANCE
PSYCHIARTRIC NURSE PRACTITIONER'S ROLE IN THE
PROVISION OF HEALTH CARE IN A PSYCHIATRIC HOSPITAL AT
UMGUNGUNDLOVU DISTRICT**

Researcher: Mrs. Ronah Tholakele Zondi
Student number: 209521222

Supervisor: Ms A A H Smith

**Submitted in partial fulfillment for the requirements for the Masters in
Nursing (Mental Health), School of Nursing and Public Health, College of
Health Sciences of the University of KwaZulu-Natal.**

November 2012

CHAPTER 1

INTRODUCTION TO THE STUDY

1.1. INTRODUCTION

This chapter introduces and presents the background to the study. It includes a brief overview of concepts and background information. In addition the problem statement, purpose of the study, study objectives and research questions, and operational definitions are presented. The chapter concludes with a description of the conceptual framework that guided the study.

1.2. BACKGROUND

The nursing profession in South Africa today is in need of care. Thousands of nurses have left the country, either temporarily or permanently, to seek better conditions abroad (Department of Health (DoH), 2004a). A study conducted by World Health Organization (WHO) stated that South Africa has lost at least 12% of its nursing staff and 41% of medical staff to migration (WHO, 2004). Those who remain face increasingly demanding workloads related to the health care priorities such as HIV and AIDS, tuberculosis (TB) and mental illness within the context of limited nurse-population ratios. Although many young people choose to study nursing and applications for nursing education programs far outnumber available places, the profession itself is not growing in proportion to the community health needs (Hartley, 2002). Attrition, both during and after training, is high and the most current statistics suggest that two-thirds of all practicing nurses are over the age of 40 (DoH, 2004a; DoH, 2007c). At the same time, the image and status of nursing is low (Hartley, 2002). Once regarded as an elite profession for women it is now overshadowed by other more attractive and lucrative careers (DoH, 2007d; Sheer & Wong, 2008). Yet nursing remains the foundation of healthcare in South Africa (SA), accounting for 80% of health care professionals, and needs to be nurtured and strengthened if the country is to overcome its challenges within the health care system. The advance nurse practitioner (APN) currently under review by the South African Nursing Council (SANC) is viewed as one way to claim back the status that the nursing profession deserves, while also responding to increasing

health care demands in a context of limited doctors and other related health care professionals (Horrock, Anderson & Salisbury, 2002; Mundinger, Kane, Lenz, Totten, Tsai, Cleary, Friedewald, Siu, & Shelanki, 2000).

International shortages in the health care are forcing health service planners to examine new models of care delivery (Daly & Carnwell, 2003; Ketefian, Redman, Hanucharunkul, Masterson, & Neves, 2001). Health care planning has identified that responding to changing health care demands involves more than simply adding new resources. A fundamental re-examination of traditionally held beliefs about the role of nursing has evolved (Radford, 2003). What is emerging is the level of practice that does not extend beyond legislative framework of the registered nurse but incorporates expanded levels of autonomy and decision making (Wilson-Barett, Barriball, Reynolds, Jowett & Ryrie, 2002; Elsom, Happell & Manias, 2009; Daly & Carnwell, 2003; De Geest, Moons, Callens, Gut, Lindpainter, Spirig & Martineau, 2008). Specifically in mental health care the landscape is changing rapidly and becoming more challenging in terms of cost effectiveness and efficiency of services. Mental health traditionally occupies a low position on public health agendas both nationally and internationally illustrated by its absence from the Millennium Development goal (MDG) despite established links between mental disorders and the MDGs (Herrman, Saxena, Moodie, 2005; Lehman, Dieleman & Martineau, 2008; Skreen, Kleintjies, Lund, Petersen, Bhana, & Flisher, 2010; WHO, 2001). Nurses, especially mental health nurses, are being asked to do more with less, the more multi skilled the health care professional the more instrumental in the provision of care that person becomes (Jones & Minarik, 2012).

Locally, and in Africa in general, nurses are working in rural areas where there is limited or no access to medical personnel and allied health professionals (Geyer, 2001; Seitio, 2006). Inadequate infrastructure provides little support to nursing practice and continuing professional development (Sheer & Wong, 2008). In countries like Botswana and SA the shortage of doctors, especially in the rural areas, has resulted in nurses adopting diagnostic decision-making functions and as a result the prescribing of drugs has been accepted historically as a nursing function, especially in Botswana (Miles, Seitio & McGilvray, 2006). Nurses within these countries have extended their roles often, as is the case with Botswana, without appropriate

training, support, legislation and regulation to do so (Akinsola, 2001; Sheer & Wong, 2008). This raises an unresolved debate regarding what is good for the nurse and the nursing profession and what is good for health care needs (Delaney, 2005). Nurses have clearly offered beneficial services, filling the gap in health care provision, both in primary and acute health care sectors. National and international literature show that they provide a specific service that is highly regarded and in demand (Gardner & Gardner, 2005; Hanrahan & Hartley, 2008; Kinnersley, Anderson, Parry, Clement, Archard, Turton, Stainhope, Fraser & Rogers, 2000; O'Reilly, 2000; Venning, Durie, Roland, Roberts, & Leese, 2000)

Within the rapidly changing health care system in SA, decentralization of health care and the integration of mental health care into mainstream health care, there is an increased need for mental health professionals who can provide cost-effective primary mental health care (Cornwell & Chiverton, 2007; Gardner & Gardner 2005). Psychiatric nurses are among the primary health care professionals charged with providing acute assessment and long term management that includes maintenance and rehabilitation strategies. Petersen, Bhana, Campbell-Hall, Mjadu, Lund, Kleintjies, Hoesegood & Flisher (2009) argue that in order for primary health care, specifically mental health care, to be effective specialist nurses must be available to build capacity within services. However, the lack of a clinical career ladder in nursing and the focus of post graduate programs has provided a disincentive to keeping the specialist nurses' involved in clinical care, despite the increasing complexity of the clinical care provided in nearly every health setting (Callaghan, 2007). Clearly the clinical setting requires the presence of nursing leadership, leaders with innovation, individual character and the courage of their convictions to guide the nursing profession to the 21st century (Callaghan, 2007). Callaghan (2007) specifically argues that the need for the APN has become a necessity. The APN has to capture the health and the minds of nurses and other health care workers so as to challenge their traditional values and transform the APN's clinical practice. This will shape the future of nursing profession

Despite the clear need for the development of the APN role this development has not been without controversy. Strong opposition has been voiced by the medical profession, and psychiatrists, on the basis that nurses do not have the educational preparation or clinical expertise to provide the standard health care equivalent to that of a medical practitioner (Elsom et al.,

2009). Some scholars and practitioners have suggested that internal division and struggles within the nursing and professional practices have contributed to its subordination to medicine and lack of professional status (Hall, 2005; Hartley, 2002; O'Reilly, 2000). Although there are definite gains to the APN, specifically the advanced practice psychiatric nurse (APPN), the state seems to remain reluctant to grant nursing full professional autonomy and jurisdiction (Salhani & Coulter, 2009). Supported by advanced education and training, nurses are formalizing and utilizing independent professional practices and research to define and evaluate nursing's work, specifically that of the APN (Salhani & Coulter, 2009).

This practice and professional development is considered to encompass reflexivity, questioning current practices to create new knowledge and improved delivery of nursing and health care services (Bryant-Lukosius, DiCenso, Browne, & Pinelli, 2004; Wilson-Barett et al., 2002; Ketefian, et al., 2001). Increasing litigation surrounding the right to health care and public demands for a more efficient and effective health service, specifically within low and low-middle income countries such as SA, has highlighted the dynamic nature of the nursing profession. As stated earlier, nurses, specifically in limited health care resource contexts, have expanded their roles to meet current health care challenges (Callaghan, 2007; Gardner, et al., 2007; Dally & Carnwell 2003; Por, 2008). That this has been effective is supported in recent studies providing evidence of the noticeable contribution of the APN to the health of clients (Ruel & Motyka, 2009; De Geest et al., 2008; Por, 2008). However this begs the question, who is the APN?

It is important to note that defining what advanced practice nursing is, and what it might become is problematic and it is suggested that this remains the basis for lack of progress. Defining the APN requires definitive clarity regarding; educational preparation and standards, regulatory control, titling, reimbursement, prescribing and referral privileges within a clearly defined scope of practice (Bryant-Lukosius & DiCenso, 2004). Current literature suggests that the APN is a registered nurse who has acquired an expert knowledge base facilitating complex decision-making, and superior clinical competencies, resulting in an advanced, expanded, level of nursing practice through a combination of expertise and education (Bryant-Lukosius et al., 2004; Ketefian et al., 2001; Carryer, et al., 2007; Lloyd Jones, 2004; Por, 2008; Sheer & Wong, 2008). The APN is able to work autonomously, or in collaboration with other health professionals and

decision makers, to meet the health needs of individual persons and communities (Miles et al, 2006). Gardner and colleagues (2007) argue that the APN's comprehensive management of clients includes referral, prescriptions of medication and ordering of diagnostic investigations. Nursing is at great pains to be clear that nursing is not medicine despite consensus that the role of an APN overlaps and encroaches to the boundaries of medical science (Boyd, 2000; Hanson & Hamric, 2003; Lyon, 2004; Schober & Affara, 2006). Despite confusion over role and scope of practice of the APN, the development of this category of nurse has, and is, being driven by socio-political and professional forces within health care delivery. These driving forces are reported to include, in no specific order, firstly, a shortage of doctors. Secondly, demands for a greater choice and accessibility to health recruitment and retention of staff, specifically in some specialities where there are new personal medical services initiatives in primary health care settings. Thirdly, the need to contain health care costs, specifically in low and low-middle income countries. Finally, the need to improve service delivery and meet targeted government health care outcomes by addressing accessibility and availability of health care services (Mantzoukas & Watkinson, 2007; Sheer & Wong, 2008; Por, 2008; Ruel & Motyka, 2009).

Although APPN have long been providers of a full spectrum of mental and behavioral health services, little is known about them (Hanrahan & Hartley, 2008). In most instances the APPN holds a master's degree or advance diploma in psychiatric mental health nursing (DoH, 2007d; George & Rhodes, 2012; Schober & Affara, 2006). In SA the current South African Nursing Council (SANC) regulation (R212, Amended January 1997) stipulates the curricula for APPN education. Competencies are categorized as 'specialist skill', and 'capita selecta' and include; advanced assessment, diagnosis, and treatment of mental health problems and complex psychiatric conditions, specialist therapy skills, management, specifically change management, and research. The APPN integrates biological, emotional, and social factors when interpreting mental health problems and major psychiatric conditions basing treatment plans on current research to optimize the mental health care users (MHCUs) capacity for recovery (SANC, R212). The implementation of this SANC regulation (R212) in the development of and APPN program began in 1998 at the University of KwaZulu-Natal's Institute of Nursing as a part time study program. The demand for this program increased in 2007 and applications continue to grow. This increase in demand is linked to the historic SA DoH agreement, called the

Occupation Specific Dispensation (OSD) in September 2007 (DoH, Annexure A of OSD document, paragraph 12). The purpose of this document was to increase salaries of public service nurses, specifically specialist categories of nurses. The APPN was recognized as a specialty category (DoH, (2007d). This has proved to be a great motivator for psychiatric registered nurses to engage in continuing education (DoH, 2007d; George & Rhodes, 2012). Despite the increase in demand for this program and the increasing approval by mental health service managers of their nursing staff to register for the course, there has been no evaluation of the impact these specialist nurses have made on mental health care services.

1.3. STATEMENT OF THE PROBLEM

Changing patterns of health care are forcing service planners to examine new service delivery models (Bryant-Lukosius & DiCenso, 2004; Gardner, et al., 2007; Ruel & Motyka, 2009). Apparent is the call for a nursing service that incorporates expanded levels of autonomy, skill and decision making (Por, 2008; De Geest et al., 2008). In response to the need for an advanced nursing service, the APN was recognised by the SANC (R212, amended January 1997), the APPN gaining specific recognition through the implementation of the advanced mental health nurse program at the University of KwaZulu-Natal's Institute of Nursing in 1998 and further recognition was in the occupational specific dispensation (Annexure A of OSD document, paragraph 12) in 2007. The opportunity for, and recognition of, continued education for the psychiatric mental health nurses has increased demands for study opportunities. Despite this increased focus and demand from nurses there is little empirical evidence in South Africa of how the APN, specifically the APPN, is contributing to professional development and improvement of health care outcomes (George & Rhodes, 2012).

1.4. PURPOSE OF THE STUDY

To explore and describe stakeholder's perceptions of the APPN's role in the provision of psychiatric mental health care in order to stimulate the stakeholder's reflexivity regarding professional and practice development and to positively affect mental health care outcomes of the MHCUs.

1.5. RESEARCH OBJECTIVES AND QUESTIONS

The research objectives were threefold. The research questions presented after each objective for readability

1.5.1 To describe stake holder perceptions of the level of knowledge and skill that the APPN should possess.

Research questions

1.5.1.1 How much research knowledge and application ability is expected of the APPN?

1.5.1.2 What are expectations regarding the APPN knowledge and skill as it relates to specific psychotherapeutic interventions

1.5.1.3 What leadership role should the APPN fulfil?

1.5.2 To describe the stakeholder's expectations of the positive impact that the APPN would have in the delivery of mental health / psychiatric care.

Research questions

1.5.2.1 What formal and or informal outcome indicators do stakeholders use to determine the effectiveness of the APPN in the provision of care?

1.5.2.2 What behaviour do stake holders perceive to characterise an APPN?

1.5.2.3 Have stake holder's expectations been met?

1.5.2.4 What do stake holders perceive to be the barriers to their expectations being met?

1.5.3 To describe processes that have been instituted to facilitate the implementation of the APPN role in provision of health care

Research questions

1.5.3.1 What is the current model of care?

1.5.3.2 Are the APPN able to perform as autonomous individual?

1.5.3.3 Are they able to make decisions regarding implementation of health care projects?

1.5.3.4 Do they have support of the management to effect change?

1.6. SIGNIFICANCE OF THE STUDY

Since there are not many studies being published on the APN, specifically the APPN, in Africa, specifically South Africa, it is suggested that the findings of this research will inform policy makers, both national and provincial, regarding the value of APPN role within the mental health care system. In addition, at a time when the SANC is realigning nursing qualifications with the national qualification framework and elevating nursing qualifications to degree rather than diploma level it is suggested that the results of this study can assist to inform the position and role of the APPN within the new qualifications framework. At a service level the results of the study may highlight actual and potential barriers to implementation of the APPN role. The findings of the study are suggested to stimulate reflective practice of those participating, managers and APPN's, and can facilitate improved service delivery and MHCU positively impacting on mental health care outcomes. The information about the roles and skills of the APPN is evidence based data which can be used in developing capacity among staff through the provision of locally appropriate and ethical evidence based education and in-service education programmes. The disseminated study findings through publication may contribute to the local body of SA APPN knowledge and serve as a resource for further research in this area.

1.7 OPERATIONAL TERMS

The following terms were operationalized in this study

1.7.1 Perceptions: According to Oxford Dictionary (2012) Perceptions are the processes by which people translate and understand sensory impressions into a coherent and unified view of the world around them. Perception is equated with reality for most practical purposes and guides human behavior. In this study perceptions are the verbal comments of the participants regarding the APPN.

1.7.2 Advanced Nurse Practitioner (ANP): Is defined as a person who focuses on primary care, health assessment, diagnosis and treatment. This category can work with medical officers on a referral basis. In South Africa, this category is closer to Primary Health Care (PHC) nurse and at

time the midwife, psychiatric and paediatric nurse working outside the formal hospital environment.

1.7.2 Advanced practice nursing (APN): This involves multiple interacting role domains broadly related to clinical practice, education, research, professional development and organizational leadership. It describes the work of nurses who have additional skill and training beyond basic qualification (Carryer et al, 2007; Por, 2008; Sheer & Wong, 2008, SANC draft position paper, 2012). In this study advanced nursing practice is specific to the advanced practice psychiatric nurse (APPN), see point 1.7.3.

1.7.3 Advanced practice psychiatric nurse (APPN): An APPN is a registered nurse (RN) who has completed a additional qualification in psychiatric mental health nursing and has registered this qualification with a nationally recognized professional council. For the purpose of this study the APPN has an additional qualification in psychiatric mental health nursing registered with the SANC (R212) and provides direct clinical services for MHCUs

1.7.4 Advanced practice nursing roles: These are the roles that focus on meeting the MHCUs needs by maximizing the use of nursing knowledge and skills and improving the delivery of nursing and health care services. The roles are built upon extensive clinical experience characterized by specialization. APN roles require graduate education, involve autonomous and expanded practice. They also include multiple domains related to clinical practice, education, research, professional development and leadership (Offredy and Townsend, 2000, Bryant-Lukosius & DiCenso, 2004, Ruel & Motyka, 2009)..

1.7.5 Stakeholders: According to the Oxford Dictionary (2012) a stakeholder is anybody who can affect or is affected by the organization, strategy or projects. They can be internal or external and they can be senior or junior levels. For the purpose of this study the stakeholders will refer to APPN's and hospital and clinic mental health care managers, specifically those involved in the selection of nursing staff for advanced training.

1.7.6 Psychotherapeutic interventions: These are defined as the treatment of mental and emotional disorders through the use of psychological techniques designed to encourage

communication of conflicts and insight into problems (Wheeler, Cross & Antony, 2000). For the purpose of this study psychotherapeutic interventions will include the following activities implemented by the APPN: psychosocial rehabilitation, cognitive behavior therapy, psychotherapy and group activity.

1.7.8 Psychiatric registered Nurse: A registered psychiatric nurse a person who has undergone training for 1 year diploma (R880) or comprehensive 4 year course (R25). This person can work independently guided by the scope of practice or as a team member. They have less autonomy when compared with the APPN. (Nursing Act 33 Of 2005)

1.8. THE THEORETICAL FRAMEWORK

1.8.1. INTRODUCTION

The participatory, evidenced based, patient MHCU focused process for guiding the development, implementation, and evaluation of advanced practice nursing (PEPPA) framework was used for this study. This framework was designed to overcome role implementation barriers through knowledge and understanding of APN roles and environments (Bryant-Lukosius & DiCenso, 2004). The PEPPA framework was considered an ideal fit for this study, the underlying principles and values consistent with advanced practice nursing, specifically advanced practice psychiatric nursing. These include a focus on addressing MHCUs health needs through the delivery of coordinated care and collaborative relationship among health care providers and systems. The principle assumption of the framework being that all stakeholders, regardless of their roles, have the capacity to reflect, learn, inform and work to improve the model of care (Bryant-Lukosius & DiCenso, 2004). This framework draws on a large body of knowledge related to the implementation of APN roles, applies accepted principles of participative action research and implements the evidenced-based processes as outlined by Spitzer (1978). The PEPPA framework is considered valuable whether introducing the APPN role or facilitating its development and implementation (Bryant-Lukosius & DiCenso, 2004; Cameron & Masterson, 2000)

The framework, with implementation steps, is diagrammatically represented in Figure 1.1, page 12. There are nine steps within the framework and they will be described as they apply to the development of the APPN role. Step 1, defining the population and describing current model/s of care includes mapping how MHCUs enter the health care system and interact with the health care providers and service over a specific period of time or continuum of care. Relationships and interactions can be defined from the team, organizational and or geographical perspective. The MHCU population can be specifically defined. For example, in considering an APPN role for MHCUs the population could be limited to those with serious mental conditions such as schizophrenia. The continuum could begin at the time of 72 hour admission to a district general

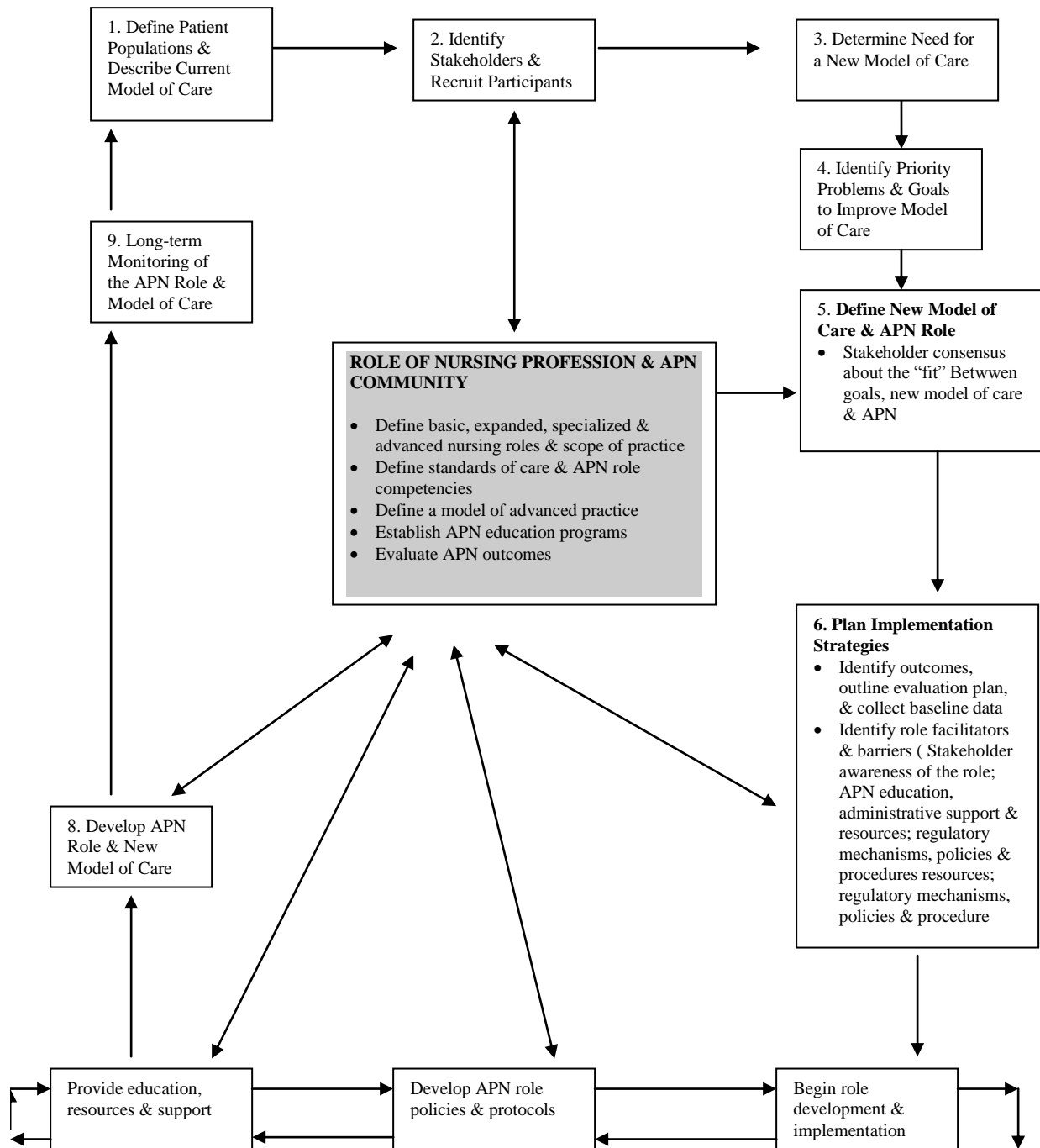


Figure 1: The PEPPA Framework: a participatory, evidenced-based, patient-focused process for advanced nursing (APN) role development, implementation, and evaluation (adapted from Spitzer 1978, Dunn & Nicklin, 1995, Mitchell-DiCenso et al., 1996)

hospital and continue through transfer to a psychiatric institution including discharge and psychosocial rehabilitation or merely focus on the 72 hour admission to a district general hospital. The second step involves the identification of key stakeholders and the recruitment of participants.

Stakeholders may come from a variety of backgrounds and professional associations. Nursing's involvement in defining the purpose and objectives of the APPN role is a prerequisite for establishing a culture of shared values and beliefs necessary to operationalize the role. Equally the support of the key players is recognized as critical to the successful implementation of the APPN role (Carrier, Gardner, Dunn, and Gardner 2007). The third step aims to analyze the strengths and weaknesses of the current model of care in order to inform the creation of a new model of care. This analysis includes key issues related to needs of all stakeholders, -MHCU and their family / care givers, professional and organizational as well as information resources and appropriate methodology to acquire information. Health care literature and institutional or national databases may provide epidemiological data while focus groups or in depth interviews are used to gain knowledge of stakeholder perceptions of the efficacy of the current model of care. Analysis considers the availability, accessibility, acceptability, awareness, appropriate use and affordability of health service and human resources for meeting the health care demands related to MHCU volume and acuity, providers/consumers satisfaction and changes in the quantity, distribution or roles of the health care providers.

The fourth step focuses on the identification of priority problems and goals. This step seeks to utilize understandings of MHCUs' needs and the strengths and weaknesses of the present model of care. Categorizing MHCU needs and health care delivery problems into groups or themes helps to identify and analyze problems. The stakeholders are asked to reach a consensus; outcomes are identified and evaluated for the new model of care. It is suggested that shifts in traditional power structures occur when participants become connected by mutual understanding and shared interest. Bryant-Lukosius and DiCenso (2004) recommend methods such as Delphi technique, consensus panels, or nominal group process to achieve consensus. Strong agreement on priorities is important for stakeholders' commitment to problem resolution. Goal identification allows participants to determine what they hope to accomplish through efforts to

resolve priority problems and provides the basis for identifying outcomes to evaluate the new model of care and the APPN role.

Step 5, the definition of the new model of care and APPN role is the action stage; changes to be made are put into place. Generating a depth and breadth of strategies to improve care is strengthened because MHCU's needs have been examined from multiple viewpoints. Greater attention must be paid to teamwork and accountability (Guest, Peccei, Rosenthal, Redfern, Young, Wilson-Barnett 2002); Hogan & Shattell, 2007; Read, 2001). The Action stage continues into step 6, developing a plan to ensure system readiness for the APPN role. There is inclusion of strategies to facilitate APPN role development, anticipating and preventing role barriers. Depending on the model of care APPN role strategies may be required to address implementation issues within and across organizations and health care settings. Stakeholder awareness of the role, APPN education, administrative support and resources and regulatory mechanisms, policies and procedures are frequently identified as APPN role facilitators and warrant particular attention during the this phase.

According to Bryant-Lukosius & DiCenso, (2004) step seven is the implementation of planned strategies in a logical sequence. These authors suggest the following; stakeholders are oriented to the role; potential role holders acquire the necessary education; administrative support and resources are in place; regulatory mechanisms, policies and procedures are established; the person is hired and role development and implementation begins. Rarely is it possible to have all strategies to support role development, full implementation of the APPN role is a continuous process that takes time. Evaluation of the APPN role and new model of care begins with step eight. This step involves a comprehensive structure-process-outcome evaluation of the new model of care and APPN role. Inclusion of the model of care in this evaluation will help identify how roles, relationships and resources impact on APPN outcomes. Briefly, structure refers to resources, the physical and organizational environment and characteristics of the APPN. Process refers to the type of services, how services are provided and how the APPN role functions related to practice, education, research and organizational and professional leadership. Outcomes are the results of care and identified through health care outcomes. Studies of the new APPN and health care provider roles have demonstrated the importance of structure and process evaluations

to identify role barriers and facilitators. APPN activities are linked to the specific health care outcomes such as prevention of complications, staffing patterns and practices, length of stay, costs and readmission rates. Long term monitoring of the APPN role and model of care is described as step nine. The mental health care environment is dynamic and thus the APPN role should also evolve to meet changing population needs. The process for role development, implementation, and evaluation is iterative.

1.8.2. THE UNFOLDING OF THE THERORETICAL FRAMEWORK IN THIS STUDY

This study focused on steps 1, 2, and 3 of the PEPPA framework. In Step 1 the researcher described the MHCU population, the admission procedure and the model of care MHCUs were exposed to. The inter relationship between the MHCU and the providers of care is discussed from a team and organizational perspective. Reflective learning is encompassed in step two. The researcher included APPN's and mental health care managers, specifically managers involved in the selection of nurses for advance practice training. The researcher orientated these participants to the process so as to establish a culture of shared values and beliefs necessary to operationalize this role. Step three was included to facilitate the analysis of the current model of care, its strengths and weaknesses. The APPN roles are concerned with assessing and managing human needs resulting from actual or potential health problems. Evidence was sought from the ward documents to check evidence of the care rendered to MHCU. Even though it was also important to find out what are the MHCU's needs, what factors can contribute in meeting these needs this was not in the scope of this research study to determine the MHCU's perception of their needs

1.9. SUMMARY OF THE CHAPTER

This chapter introduces the APN, specifically the APPN and gives a brief introduction to issues extended and expanded roles of the nurse in meeting the community's health care needs. The chapter emphasizes the central roles of the nurse in health care and the potential of the APN, specifically the APPN, in the delivery of effective, affordable and accessible care. This PEPPA framework is described as underpinning the study and suggests a process for the implementation and or development of the APN role within a health care institution.

CHAPTER 2

LITERATURE REVIEW

2.1. INTRODUCTION

This review focuses on literature and research studies related to the APN. Issues surrounding the development and credentialing of the APN and challenges faced by nurses in implementation of advanced practice roles. It should be noted that there is limited SA research and literature related to the APN, specifically the APPN. Much of the information presented in this chapter refers to current literature of international origin related to the APN rather than the APPN. The following search terms were entered in the data bases of BioMed Central, Medline- Ebscohost, CINAHL, Cochrane Library, Pubmed, Science Direct, LWW Journals @OVID full Text, Md Consult Core Collection, Health Source: Consumer Edition: "advance practice nursing"; "advanced psychiatric nursing"; "mental health and advanced nursing"; "the role of the advanced psychiatric nurse"; "clinical nurse specialist" "knowledge and retention"; "barriers in implanting advanced practice nursing roles", "Shortage of health care Staff", "Rotation of staff", "the bio-psychosocial model of nursing and psychiatric nursing"; "biological model in psychiatry".

2.2. HISTORICAL AND CURRENT PERSPECTIVE

Advanced practice nursing is a global phenomenon which has been debated in many countries since the 1960s (Coyler, 2004, Gardner, et al., 2006; Gardner, Hase, Gardner, Dunn & Carryer, 2008; Mantzoukas & Watkinson, 2007; Por, 2008). According to Ruel & Motyka (2009) the term advanced practice nursing has been used since the 1960s and defines licensed registered nurses prepared at a graduate level in nursing as a nurse practitioner, clinical nurse specialist, certified nurse midwife or certified registered nurse anaesthetist to provide direct care. Cukr, Jones, Wilberger, Smith and Stopper (2004) suggest that a major catalyst to the development of the clinical nurse specialist (CNS) role was the enactment of the 1964 Nurse Training Act in the United States of America (USA). This Nurse Training Act was, designed to support and upgrade nursing education. In most countries this CNS refers to registered nurses with advanced and

extended clinical roles. The issue of inconsistent titling is evident throughout the literature and this stumbling block to the development of the advanced practice nurse role is discussed later in the literature review. For now the researcher wishes to clarify that the advanced practice nurse (APN) will be used to encompass advanced practitioner, clinical specialist and other titles that refer to a nurse who have undergone additional education and credentialing with regards to a specific nursing clinical speciality. In addition the APN specific to psychiatric nursing will be referred to as the advanced practice psychiatric nurse (APPN).

Over the last 20 years nursing practice has become more specialized and nurses more highly skilled in response to the dynamic nature of the health care environment. This dynamic nature includes changing needs of the health care consumers, technological innovations, scientific advancement and improved educational opportunities. A key educational development internationally has been the recognition of advanced skills and knowledge held by many nurses (Sheer & Wong, 2008). As with the current state of affairs in Africa, this first recognition in the USA was related to a shortage of doctors resulting in nurses performing more medically defined tasks (Elsom et al., 2009). The shortage of health workforce is an international phenomenon (Dal Poz, Quain, O'Neil, McCaffery, Elzinga & Martineau, 2006; Sheer & Wong, 2008; Simoens, Villeneuve & Hurst, 2005; WHO, 2006). These authors point to a shortage of more than 4 million doctors, nurses and midwives. Internationally APN's evolved on an *ad hoc* basis, with different roles, responsibilities and terminology used in different countries (Sheer & Wong, 2008). The result, which is discussed later in the chapter, being that today APNs have as many titles as they do roles and there is a confusing overlap in many areas that continues to be a barrier to definitive recognition (Mantzoukas & Watkinson, 2007; Ruel & Motyka, 2009). In addition, international and some local APPNs have identified themselves as psychoanalysts, psychotherapists, family therapists or with other such labels that obscure their professional nursing identity (De Geest et al, 2008). Whether this phenomenon occurs because APPNs are trying to pass as members of a more elite mental health discipline or just lack marketing know-how, opportunities for consumer education about and marketing of APPNs and the value of the mental health services they provide are lost (Mantzoukas & Watkinson, 2007; Ruel & Motyka, 2009).

Currently SA professional nursing registration with the SANC does not distinguish between an APN and APPN, who obtained the qualification through an advanced diploma qualification or from masters, there is merely the registration of an additional qualification in the specialized area. This has resulted in uncertainty about the status and classification of APN's in South Africa, and has implications for remuneration and clinical career-pathing (SANC, Advanced Practice Nursing-Draft position paper 2012). In addition APN, including the APPN, have no prescription authority (Elsom et al., 2009; Pearson & Peels, 2002). The SANC has recently recognized that beyond a general nurse or midwife practitioner, there is a need for the APN. The SANC, in their Advanced Practice Nursing Draft Position Paper (2012), argues that within advanced practice nursing, there should be two categories or levels (SANC, Advanced Practice Nursing-Draft position paper, 2012). Firstly, the nurse specialist who requires in-depth knowledge and expertise in a specific clinical practice area such as psychiatric nursing. To become a nurse specialist would require a post-graduate diploma (PGD) in the specific specialization. This qualification will yield a professional registration with the SANC as a nurse specialist stipulating the area of specialization, for example, nurse specialist: psychiatric nursing. The advanced nurse specialist, the second category, has to acquire a broader field dynamics at a master's level. This second level qualification will yield no professional registration but can be logged as an additional qualification with the SANC (SANC, Advanced Practice Nursing-Draft position paper, 2012). The draft paper is less clear regarding scope of practice.

Current literature suggests that APN's scope of practice includes the provision of comprehensive management of clients that includes referral to other healthcare professionals, prescriptions of medication and ordering of diagnostic investigations (Gardner et al., 2008). However, as stated in the background in chapter 1, it is essential to understand that nursing is not medicine despite consensus that the role of an APN overlaps and encroaches to the boundaries of medical science (Hanson & Hamric, 2003; Lyon, 2004; McDonald, Bennett, Dwyer & Martin, 2006; Schober & Affara, 2006). APN practice is guided by a nursing framework that argues for autonomous but collaborative functioning with other health care team members (Rapp, 2003; Carryer et al., 2007). However, there remains confusion and disagreement regarding core issues such as a standard name for the APN, the scope of practice and the philosophy underpinning of educational preparation (Bryant-Lukosius & DiCenso, 2004; Mantzoukas & Watkinson, 2007;

Cukr et al. 2004; Por, 2008). These authors suggest that public opinion should be sought, stating that this confusion causes a lack of understanding between nursing and society as to the functions of the APN. Despite this lack of consensus current literature continues to argue that the APN shows potential to contribute favorably to guaranteeing optimal health care, especially within the mental health care system (De Geest et al., 2008; Mantzoukas & Watkinson, 2007). Mantzoukas and Watkinson (2007) suggest that the common goal and desire of nurses is the attainment of autonomous practice and professional integrity to improve the provision of care.

2.3. WHAT SHALL THE NAME BE

As stated earlier in the chapter there is confusion within the nursing profession regarding the terminology used to describe the APN. According to Breier, (2007) and Elsom et al., (2009) identity confusion is further enhanced by regulatory issues associated with the plethora of APN titles promulgated by State Boards of Nursing, particularly in the USA. These boards use differing titles to codify advanced practice categories as well as determine which advanced practice categories are granted prescriptive authority. For example, within the USA each state Nurse Practice Act is different in what it codifies. For example, in Washington, Oregon, Montana, Florida, and Iowa all APNs, irrespective of advanced practice category, are licensed as Advanced Registered Nurse Practitioners (ARNP) and those who meet the requirements for prescriptive authority are licensed as Advanced Practice Registered Nurses (APRN). In Alaska and Wisconsin, the license is APN or APN-P (advanced practice nurse and advanced practice nurse with prescriptive authority). In New York, nurse practitioners (NPs) are the only APN category codified in the Nurse Practice Act, thereby granting them prescriptive authority. APPN's who want to obtain prescriptive authority and meet the state credentialing requirements (45 hour pharmacology course) are certified by the State Education Department as Psychiatric Nurse Practitioners and are no longer considered CNSs. Clearly the differing titles in the evolution of the APN are confusing and a serious barrier to the APN, and the APPN explaining exactly who they are (Elsom et al., 2009; Pearson & Peels, 2002). In addition authors suggest that public recognition of and attribution of meaning to titles is critical in the development of the APN role. For example, the meaning of the title 'clinical nurse specialist' in psychiatric-mental health nursing is not well understood by legislators, health administrators, or the consumer

public while ‘nurse practitioner’ is suggested to have achieved a high level of name recognition (Callaghan, 2007; De Geest et al., 2008) . The public understands what primary care is and associates nurse practitioner’s as providers of primary care in outpatient settings (Miles et al., 2006). This may explain the SA APPN tending to refer to themselves as clinical nurse specialists, in an effort to distinguish themselves from primary health care nurses.

Understanding the difference between these related concepts is crucial for defining and developing the full potential of the roles (Bryant-Lukosius et al., 2004). It is not just the number of terms, but the variation in the meanings ascribed to them that are problematic. For example, ‘advanced nursing’ and ‘nursing practitioner’ are now often used interchangeably with little consideration of the potential impact on other advanced nursing roles (Elsom, et al., 2009). Advance practice has been defined by some authors in terms of the degree of autonomy enjoyed by the nurse in the form of extended and expanded practice roles whereas for others the scope of clinical practice is less important in defining advanced practice than the level of expertise of the nurse in performing identified nursing tasks (Daly & Carnwell, 2003). The lack of uniformity in definitions and terminology is not peculiar to the USA and is particularly evident in the Position Statement on Advanced Practice Nursing (2000) published by the Royal College of Nursing Australia (RCNA). The RCNA definition of advanced practice nursing states that it utilizes extended and expanded skills, which APNs may work in a specialist or generalist capacity (Bryant-Lukosius et al., 2004, Daly & Carnwell, 2003). In this document the RCNA also asserts that APN forms the basis for the role of nurse practitioner and that the nurse practitioner role is an expanded form of APN. Clearly a confusing blend of overlapping titles.

Clearly titling is intertwined with educational preparation, role definition and to a greater or lesser extent scope of practice. Bryant-Lukosius (2004) and Gardner and Gardner (2005) proposed a definition that can be implemented when discussing APN. These authors suggest that APN incorporates those roles extending beyond the traditional scope of nursing, involve interacting role domains broadly related to clinical practice, education, research, professional development and organizational leadership. Advancement is conceptualised as the specialization and expansion of knowledge, skills and role autonomy. It includes professional activities that lead to innovation and improved nursing care underpinned by a commitment to a nursing

orientation to practice. Current literature describes the APN as embracing a variety of roles in which the nurse functions at an advanced level of practice. These roles require graduate education, practice experience, licensure and certification. In addition there is recognition that the APN role develops in response to contextual issues such as organizational structure and culture, societal values and expectations, local health care demands and needs, workforce demographics, practice trends and economic trends. It is suggested that these inform health care policies and legislation related to regulatory and credentialing mechanisms. Although APNs can function in various role domains broadly related to education, research, professional development and organizational leadership there is consensus in several practice models that clinical practice is the primary focus of the APN. Daly & Carnwell 2003; Gardner, et al., 2008; Hamric 2000 developed a framework to overcome some of the existing confusion surrounding higher levels of nursing practice and the terminology used to describe them. These authors explain the concepts of role extension, role expansion and role development as a means to describe and categorize the changes in skills and boundaries of practice in nursing.

2.4. ROLE EXTENSION, EXPANSION AND DEVELOPMENT

Daly and Carnwell (2003) framework explains each of these concepts as they relate to nursing practice and the environmental contexts in which they may arise.

Firstly, role extension is described as the inclusion in a nurse's role of a skill or responsibility which was not previously a nursing role, a skill or responsibility which typically has been regarded as the domain of another profession. For example, prescriptive authority, historically regarded as the role of the doctor (Dally & Carnwell, 2002; Elsom et al., 2009). The rationale for role extension was generally to provide continuity of important aspects of care in the absence of other professionals (Dally & Carnwell, 2002, Elsom et al., 2009; Ketefian et al., 2001). Role expansion occurs when with the additional skills and responsibilities there is also additional autonomy and accountability while maintaining the core elements of nursing practice. (Elsom et al., 2009,) As with role extension the additional skills and responsibilities may also be traditionally regarded as part of the domain of another profession. However, the difference between extension and expansion relates to a more formalized educational preparation in role

expansion that is absent in role extension and forms the basis for increased autonomy and accountability (Daly & Carnwell, 2003). Finally, Daly and Carnwell (2003) describe role development as a new role that not only embraces aspects of extension and expansion but also involves higher levels of clinical autonomy. These authors argue that role development is brought about by new health care demands and perceived shortcomings in the quality of care and health care resources. The outcome of role development is a change in the fundamental nature of service provision and specifically in the scope of practice of nursing. This logically builds on specialist practice and is coherent with greater responsibility, accountability and autonomy through the development of expert practice based upon an extended period of professional education and experience (Callaghan, 2007; Carryer et al., 2007, Daly & Carnwell, 2003). Role development is similar to Benner's (1984) fourth level of proficiency; the nurse has a specialist's role, additional skills and areas of practice.

These concepts of extension, expansion and development can be related to workforce challenges in health care such as the shortage of primary care physicians. However, the enduring existence of role extension and role expansion necessitating role development to facilitate positive health care outcomes through formalized education and skill development. It is within this health care context that the APN emerged, to respond to community health care needs (De Geest, 2008; Miles et al., 2006).

In mental health care facilities, especially in low and low-middle income countries and underdeveloped countries, this need for role development is imperative since psychiatry is the most neglected part of health care; several countries allocating less than 1% of their budget to this area of care (Saraceno, Ommeren, Batniji, Cohen, Gureje, Mahoney, Sridhar & Underhill, 2007). In low-middle income countries like SA, care in psychiatric services is predominantly rendered by nurses. The SANC recognition of the APN and the development of an APPN role was highly welcomed since the nurses were practicing, through role extension and role expansion, out of their scope of practice (De Geest, 2008). The APPN acquisition of expertise can be linked to Daly and Carnwell's (2003) of role extension, role expansion and role development (Daly & Carnwell, 2003; Mantzoukas & Watkinson, 2007). This conceptual framework is suggested to be aimed at development and integration of clinical practice,

education, management and research to advance and clarify distinctions between the roles associated with APN. That the SANC is currently continuing to build on the APN role is a clear indication of role development (SANC, 2012).

Hogan & Shattell, (2007) describe the field of APN as a pyramid. At the base are environmental factors that support the apex or purpose of APN roles, As with Daly and Carnwell's (2003) conceptualizations of role extension and expansion, Hogan & Shattell (2007) highlight that environmental factors influence the purpose and nature of APN roles and the resources and structures permit advanced nursing practice to occur. In countries such as the United States, where legislation, regulatory mechanisms and protected titles for clinical nurse specialists, nurse midwives, nurse anesthetists, and nurse practitioners exist, there is less difficulty distinguishing APN roles. However, most countries do not have protected titles and role confusion arises when the same title, such a nurse specialist is applied to different roles with varied purposes, educational preparation, and scopes of practice (Bamford & Gibson 2000)

2.5. COMPETENCIES, CHARACTERISTICS, EDUCATION REQUIREMENTS

Previous sections of this chapter have hinted at competencies and characteristics and post graduate education preparation of the APN. In this section the researcher attempts to present a composite picture based on current literature. At the onset it is necessary to define the concept of advancement as it relates the nursing practice and the relative consensus regarding a minimum graduate education. Advancement, as in advanced practice, is broadly defined as the integration of theoretical, research-based, and practical knowledge that occurs as part of graduate nursing education (Elsom et al. 2009; Furlong & Smith, 2005; Hanson & Hamric, 2003; McGee & Castledine, 2003; Pearson & Peels, 2005).

Current literature and APN practice models argue that the APN is a registered nurse with a graduate degree who is an expert in a defined area of knowledge and practices in a selected clinical area where he/she strives to improve patient care through three distinct spheres of influence, patients, nurses and organizations (Bryant-Lukosius et al., 2004; Kring, 2008; Hamric, 2000; Pearson & Peels, 2002). This multilevel focus allows the APN to influence outcomes not

only through bedside practice but also by mentoring and educating nurses, and contributing to organizational process and policy decisions (Kring, 2008; Pearson & Peels, 2002). An APN is a practitioner, researcher, consultant, educator and a leader (Bryant-Lukosius et al, 2004). As stated earlier in the chapter numerous environments influence the development, implementation and evaluation of APN roles, specifically local conditions such as culture, the health care systems, organizational culture, government ideology, the nursing profession, and the APN community itself (Brown 1998; Read, 2001; Hamric, 2000; Breier, 2007). Despite this contextual development of the APN current literature suggests the existence competencies of the APN (Carryer et al., 2007; Hamric, 2000; Pearson & Peels, 2002; Rapp, 2003). These authors suggest that core competencies include: expert clinical practice; expert guidance and coaching of patient's families and other health care providers; consultative and collaborative skills; clinical and professional leadership; change agent skills and ethical decision making skills. According to the Bryant-Lukosius and colleagues (2008) expert practitioners need to demonstrate exemplary critical thinking skills in practical and theoretical knowledge in the course of their practice. Clearly these competencies suggest a higher level of clinical autonomy in making decisions regarding clinical practice. Smith (2003) maintains that when expertise is interwoven with diverse theoretical knowledge it allows the APN to adapt and deliver care to patients in any given situation including those hindered by protocol.

Despite some minor differences, literature is explicit regarding characteristics that distinguish APN practice from basic nursing practice (Elsom et al., 2009; Pearson & Peels, 2005) firstly, specialization or provision of care for a specific population with complex, unpredictable and/or intensive health care needs. Secondly, an expansion or acquisition of new knowledge and skills. Lastly, the achievement of role autonomy that extends beyond traditional scopes of nursing practice and advancement, which includes specialization and expansion. Implicit characteristics include; innovation, orientation to practice and synthesis of knowledge and skills (McGee & Castledine, 2003). Innovation involves professional activity that promotes development of new nursing knowledge or improves nursing care. Professional activities include evaluating nursing interventions, enhancing the nursing role in new models of care delivery or facilitating change in health care policies and practices (McGee & Castledine, 2003). Innovation or the advancement of nursing practice cannot occur without commitment to the fundamental values of the

profession. These values involve a nursing orientation to practice that is patient-centered, health-focused and holistic (O'Connor & Furlong 2002). Advancement involves purposeful actions to improve health through integration of knowledge and skills related to clinical practice, education, research, professional development, and organizational leadership (McGee & Castledine 2003; Furlong & Smith, 2005; Bamford & Gibson, 2000; Jones 2004). Hanson & Hamric, 2003 refer to this integration of role domains as the synthesis of competencies. The ability to synthesize and apply this depth and breadth of knowledge suggests that advancement involves more than expertise developed through experience, rather post graduate education that facilitates high levels of critical thinking and analysis is required (Hanson & Hamric, 2003; McGee & Castledine 2003). Advancement also occurs when advanced nursing practice role domains function synergistically to produce a whole that is greater than the sum of its parts (Hanson & Hamric 2003). Acquisition of specialty or expanded clinical knowledge and skills is not indicative of advanced practice unless clinical practice directs and is guided by the knowledge and activities of other role domains to improve patient care. Therefore, roles extending beyond traditional boundaries of nursing practice, but designed only to provide clinical care, represent expanded but not advanced nursing practice, nor role development.

2.6. CREDENTIALING

Credentialing is essential to recognition and role development. However, as indicated in point 2.3 of this chapter, APN credentialing requirements are not uniform globally or nationally within many countries. Without credentialing a scope of practice is not evident. In countries where the specifically the APPN, are fully recognized and functional, such as the USA, their role is governed by a Scope of Practice (Jones, 2010). In African countries, such as Botswana, APPNs practice without a defined scope or legislative authority (Jones, 2010). As stated earlier, in SA the SANC gave credentialing to the APN in 1997. Despite this, the scope of practice of the APN was and is not clearly defined. Current authors suggest that this is not unusual (Gardner & Gardner, 2005; Jones, 2010; Offredy & Townsend, 2000). These authors note that even in countries where APNs are well established there is often difficulty in interpreting the scope of practice due to the broad interpretation of the term advanced practice (Gardner & Gardner, 2005; Jones, 2010; Offredy & Townsend, 2000). It is thus suggested as critical that at the time of

review of nursing education in SA that the nursing profession, specifically APNs and APPNs, are responsible to engage in the current debate to ensure their input in defining APN roles, establishing standards for practice and education, and regulating and monitoring APNs to ensure the safety, effectiveness and quality of practice (Furlong & Smith, 2005; Carryer et al, 2007; Pearson & Peels, 2002). Carryer and colleagues (2007) urge APNs to embrace their obligation to advocate for their client base and their profession at the system of level of care (Carryer et al. 2007). This requires leadership. Current authors suggest that the success of the APN as a transformational leader will depend on the development of a nurse leadership culture whereby bureaucratic organizational structures give way to more proactive, supportive and enabling environments (Bryant-Lukosius & DiCenso, 2004; Clarke 2000; Carrol, 2002; Furlong & Smith 2005; Mahoney 2001; Sullivan & Decker, 2000). Although there is little empirical evidence in SA, these authors argue that APNs have developed a new level of health service that builds upon extensive clinical experience and educational input that is characterized by specialization and provides health service to the population that previously had poor access thus impacting on health care outcomes (Bhengu, 2009; Gardner & Gardner, 2005; Flisher, Lund, Funk. Bhana & Doku, 2007).

2.7. PROFESSIONAL DEVELOPMENT AND HEALTH CARE OUTCOMES

According to the WHO (2006), psychiatry and mental health services in Africa are 90% run by nurses. This is argued to be due to the shortage of doctors in mental health (Callaghan, 2007; WHO, 2006). In general health care and psychiatry the shortage of doctors has prompted an urgent need for reform within the health care system in order to ensure an adequate supply of health care professionals and address serious issue of unmet community health care needs (Gardner & Gardner, 2005; Pearson & Peels, 2002). Authors argue that the skills and accessibility of the APN are highly suitable to the contemporary health care environment (Callaghan, 2007; Elsom et al., 2009; Pearson & Peels, 2002). The development and presence of such expertise in the health care system has many potential benefits. Firstly, the development of the nursing profession and secondly, improved health care outcomes, including an impact on cost, as APNs are utilized to fill the gaps in the health care system, (Callaghan, 2007; Elsom et al., 2009; Pearson & Peels, 2002).

Specific to health care outcomes, there is evidence that the APN's offer a beneficial service and fill a gap in health care provision, both in primary and acute health care sectors. National and international literature reports that APNs provide a dynamic and yet specific service that demonstrates the application of high level clinical knowledge and skills in a wide range of contexts (Horrock et al., 2002; Kinnersley, et al., 2000; Venning et al., 2000). Nurses at an advanced level, specifically in APPNs in SA, are striving to develop their expertise and initiate nurse led services in collaboration with other professionals in an effort to provide the highest quality care (Brant-Lukosius et al., 2004; Bryant-Lukosius & DiCenso, 2004; Furlong & Smith 2005; Jones, 2005; Por, 2008, Sullivan & Decker, 2000). There is consensus that APNs are legal, economic and professional change agents who contribute to the profession in numerous ways (Bryant-Lukosius & DiCenso, 2004; Bryant-Lukosius et al., 2004; Gardner et al., 2007; Hanson & Hamric, 2003; Mantzoukas & Watkinson, 2007). These authors suggest that the APN can influence change within five main categories or sub-roles; clinical practice, education, research, professional development and organisational change (Bryant-Lukosius & DiCenso, 2004; Bryant-Lukosius et al., 2004; Gardner et al., 2007; Hanson & Hamric, 2003; Mantzoukas & Watkinson, 2007).

Specific to the APN, research has shown significant contributions to the care of patients. Firstly a randomised controlled trial was done in United Kingdom by Venning and colleagues (2000) with a sample of 200 people. Venning and colleagues (2000) compared the cost effectiveness of General Practitioners (GP) and APN in 20 general practices. The APNs involved in the survey were qualified registered nurses studying for a Master degree with experience ranging between 1 and 5 years. Results showed that; APN consultations were longer than the GP consultations; APN ordered more tests and asked patients to return more often. There was no significant difference in patterns of prescribing or health outcomes. Patients were more satisfied with NP than the GP even when the length of consultation was controlled for. A second randomised control trial study conducted by Kinnersley and colleagues (2000) consisted of a sample of 1368 patients from 10 general practices in South Wales and South east England. The APNs included in the study had to have completed a recognized programme of education to diploma level and have been qualified for at least one year. Results of this study support the previous study by

Venning and colleagues (2000) indicating that patients consulting an APN were significantly more satisfied with their care. Patients seen by the APNs reported receiving significantly more information about their problems than those managed by GP's. Resolutions of symptoms and patient's concern showed no difference between APNs and GPs. Number of investigations ordered, prescriptions issued, referrals to the other agencies and re-attendance rates were also similar. These studies provide outstanding evidence in support of the capability of APN to develop new roles and provide high quality cost-effective care in primary health care settings (Daly & Carnwell, 2003). Finally, a third randomised controlled trial conducted by Mundinger and colleagues (2000) sampled 1316 adult patients and compared specific indicators of care between the ANP and physician care in a primary care setting. The findings suggested no significant differences in diagnostics other than the APNs recorded significantly lower diastolic values for hypertensive patients than physicians. There were no significant differences in the patients' utilization of health service between groups at 6 months and 1 year and no difference in patient's satisfaction ratings following consultation.

The professional benefits of role development, specifically the APN role are argued to be extensive. It is without a doubt that the development of the ANP role has many potential benefits to the nursing profession: improvements in quality of care, effective use of resources, cost containment, reduction of waiting times and medical workloads while maintaining and or increasing levels of patient's satisfaction.

2.8. SUMMARY OF THE CHAPTER

Nurse practitioner roles have also developed in response to health needs in under-serviced, rural, and remote populations (Duffy 2001; Pilane, Ncube, & Seitio, 2007). The health care system influences APN roles through fluctuations in the supply and demand of care providers, new practice trends, and economic pressures affecting the delivery of health services (Whyte, 2000, Wilson-Barrett 2002). The development of the APN has been motivated by a shortage of doctors, and patient's demands for greater choice and accessibility of health care as well as national service frameworks and government targets for health care outcomes (Cukr et al 2004; Por, 2008). Despite issues of titling and scope of practice associated with specific practice roles,

these developments provided nurses with opportunities for new roles in dynamic health care environments. Advanced practice is engaged in by nurses who participate in direct care, are already at the specialist level of practice and have successfully completed advanced education. The APN, specifically in SA, needs to recognize and strive for recognition and integration of five aspects of their role; clinical expert, researcher, teacher, consultant and capacity builder, and leader (Callaghan, 2007; De Geest et al, 2008; Pearson & Peels, 2005).

CHAPTER 3

RESEARCH METHODOLOGY

3.1. INTRODUCTION

The general purpose of a systematic process of investigation is to contribute to the body of knowledge, shape and guide academic and or clinical practice disciplines (Powers & Knapp, 2000). This chapter describes the research methodology and includes the research design, research population, research setting, sample and sampling methods, data collection procedure and a description of the data analysis process. In addition ethical issues and measures to ensure academic rigor and trustworthiness are described.

3.2. RESEARCH PARADIGM

The interpretive paradigm was used to guide the inquiry. This paradigm perceives the social world as a process created by individuals. The proponents of this paradigm believe that the truth lies with the individual and therefore data was collected qualitatively (Paudel, 2005; Weaver & Olson, 2005). To achieve this, Focus Group Discussions were used to address the objectives.

3.3. RESEARCH DESIGN

A qualitative design was used to explore the perceptions and knowledge of APPNs, and service managers, about the APPN role in rendering care to MHCU within a psychiatric hospital setting. This design was used because it allowed the researcher to gain insight and understanding of participant's knowledge, expectations and current role implementation processes which was difficult to quantify (Brink, 2006; Burns & Grove, 2009; Holloway & Wheeler, 1996). The researcher conducted in-depth focus group interviews to collect narrative data from the participants using an exploratory approach (Polit & Beck, 2012). The limited evidence based knowledge about the role of the APPN in mental health care services lends itself to a qualitative enquiry where the focus is on recording and analyzing accounts of previously unaccounted for

social phenomena (Silverman, 2001; Terre Blanche & Durkheim, 2001; Willing, 2002). There is little empirical research about this area of practice within the SA context. According to Cresswell (1998), qualitative research is a process of inquiry that explores social phenomena or human problems and experience, and is particularly useful where little is known about the phenomena. This study aims to uncover and share light to the role of the APPN in the nursing profession.

3.4. RESEARCH SETTING

The study was conducted at a tertiary psychiatric hospital situated in the Midlands region of UMgungundlovu District, KwaZulu-Natal province, SA. This psychiatric hospital caters for a catchment area that includes UMgungundlovu and UMzinyathi districts. The specialist hospital is part of the district health care system and is at the end of the referral pathway. Briefly, both national and provincial mental health care services are integrated into general health care services, the treatment pathway beginning at primary health care clinics (PHC). From these clinics mental health care users may be referred to district hospitals and from district hospitals to tertiary psychiatric hospitals. The selected tertiary hospital caters for an average of four hundred and twenty five (425) MHCUs at any given time. Services provided include; acute care (seven units; 3 female and 4 male, each with a capacity for 25 MHCUs), Pre discharge care (three units; 1 female and 2 male, each with a capacity for 20 MHCUs), psychotherapy (one unit; mixed gender with a capacity for 30 MHCUs), psycho geriatric care (three units; 1 female and 2 males, each with a capacity for 20 MHCUs), child assessment unit (one unit; mixed gender with a capacity for 15 MHCUs) and an out-patient department that sees an average 80-100 MHCU per month. The hospital admits 45 to 80 MHCU a month and up to 1200 per year (Hospital statistics, 2010-2011).

The hospital senior management team includes: hospital manager, medical manager, principal psychiatrist, finance and systems manager. Nursing management includes one (1) nursing manager, five (5) assistant nursing managers, one (1) student liaison manager and thirteen (13) operational managers at unit level. The nursing staff complement of three hundred and thirty two (332) nurses includes one hundred and seventeen (117) registered psychiatric nurses (basic

diploma qualification), twenty five (25) APPNs, fifty nine (59) enrolled nurses and one hundred and eleven (111) enrolled nursing auxiliaries. In addition there are twenty eight (28) doctors, seven (7) psychologists, three (3) occupational therapists and seven (7) social workers.

3.5. POPULATION AND TARGET POPULATION

The population included two distinct categories of staff within mental health services. Firstly, the APPNs who have completed the South African Nursing Council accredited R212 course in advanced mental health / psychiatric nursing. Secondly, health care managers who are directly involved in the selection and approval of nursing staff to complete this course at a tertiary education institution. The target population included APPNs working at a tertiary psychiatric hospital and the hospital management who are members of the selection committee related to approval for further studies.

3.6. SAMPLE AND SAMPLING PROCEDURE

Convenience sampling was used to select the tertiary psychiatric hospital based on accessibility to the researcher and established contact between the researcher and nursing service management of the hospital. Purposive, non-probability, sampling was used to select study participants. This method was selected to allow the researcher to exercise judgment regarding participants who were likely to be especially knowledgeable about the phenomenon under investigation (Brink, 2006; Burns & Grove, 2009). This method was used, since the researcher wanted a sample of experts and key informants.

The researcher first identified all the registered psychiatric nurses who have completed the advanced mental health nursing course, APPNs, by using hospital records (N=25). In addition a list of the management members involved in the selection of candidates for this course was also obtained (N=6). The process of approaching potential participants, their involvement, and issues of data saturation are described under the data collection process, point 3.7., and in chapter four, page 89. In order to facilitate triangulation, institutional documents were reviewed i.e. policy and procedure manuals, activity books and in-service training records.

3.7. DATA COLLECTION PROCEDURE

Once ethical approval was received from UKZN ethics committee (Annexure F, ethical approval) the researcher approached the Provincial Department of Health for permission to collect data (Annexure C, letter of request; Annexure D, proof of permission) followed by the hospital manager (Annexure A, letter of request; Annexure B, proof of permission) before directly approaching potential participants (Annexure C & Annexure G, Information and Consent sheet).

The information and consent sheets were hand delivered to the liaison registered nurse who delivered them to the potential participants, 25 APPNs and 6 managers (N= 31). A meeting was scheduled to take place three days later. The meeting was held at the institution board room and lasted for 30 minutes. The researcher presented an outline of the study proposal and then opened the floor for questions. Potential participant questions related to issues of anonymity, time investment, and venues. They also wanted to know if the interviews were going to be done on or off duty time. They were reassured that permission had been obtained for on duty time. Although issues of saturation were a concern for the researcher twelve (n=12) APPNs and five (n=5) managers involved in selection verbalized wanting to participate and were included as the researcher did not want to exclude those who wanted to contribute. Issues of saturation are discussed in chapter 4, page 89.

At the conclusion of this meeting the number, venue and times of groups were agreed upon with management and participants so as not to interfere with the provision of services. Venues were provided by hospital management for the focus interviews and were selected for participant accessibility. Most of the interviews were conducted on a Wednesday which is the day when shifts overlap and most staff members are on duty. Before leaving the meeting participants were given consent forms to sign, if they were willing to take part in the research. These consent forms were collected by the researcher. Each focus interview session took approximately 45 minutes. The following five initial group interviews were conducted over a period of two weeks.

Management involved in selection was separated into two groups, one with two (2) participants and one with three (3) participants due to work schedules. APPN's were divided into four groups based on location. One group was conducted in the child and adolescent unit with three (3) participants, one group in the psychogeriatric unit with three (3) participants and two groups in the acute unit each with three (3) participants. In addition the researcher invited all participants to two confirmatory focus groups, scheduled 4 days after the completion of the initial groups. The first confirmatory group occurred in the acute unit venue and included two (2) APPN participants. The second confirmatory group occurred in the child and adolescent unit and included two (2) participants. In total seven groups, five initial and two confirmatory, were implemented. A total of seventeen (n=17) participants; twelve APPNs and five managers.

A semi structured interview guide was used to open and generate discussion amongst participants (Annexure I) (Burns & grove, 2009; Polit & Beck, 2012). In addition, demographic data related to the number of years of experience post completion of the advanced mental health nursing course was taken into consideration. English was used as a medium of communication since all the participants were comfortable with its use.

3.8. DATA ANALYSIS

Data collection and data analysis were done concurrently, enabling the researcher to redirect the study, in case new insights were developing (Brink, 2006). Transcription of the data commenced immediately after the first group interview by the researcher. Transcription involved typing the content of the audio recording and then listening to the audio recording while reading the transcript to ensure data from the audio tape was transcribed verbatim.

Data analysis was done manually using a thematic analysis process outlined by Braun and Clark (2006). This is a deductive method for identifying, analyzing and reporting patterns (themes) within the data. The steps in the process and their application in this study are briefly described here; a more detailed description is given in Chapter 4, point 4.3., page 41. *Familiarizing self with the data* included data transcription and reading and re reading of the data while noting down the initial ideas. *In Generating initial codes* the researcher worked systematically through

the entire data set, giving full and equal attention to each data item and identifying interesting aspects in the data items that formed the basis of repeated patterns (themes) across the data set. All actual data extracts were coded during this stage. In *Searching for themes* the researcher refocused the analysis at the broader level of themes rather than codes. Firstly, the different codes were sorted into potential themes which were followed by collating of all the relevant coded data within the identified themes. *Reviewing themes* involved checking if themes worked in relation to the coded extracts, generating a thematic map of the analysis. This was followed by *Defining and naming the themes*, refining the specifics of each theme and overall story the analysis tells while generating clear definitions and names for each theme. The final step of *producing the report* provided the final opportunity for analysis, the selection of vivid compelling extract examples relating back to the research question and literature.

3.9. TRUSTWORTHINESS, DEPENDABILITY AND ACADEMIC RIGOUR

Trustworthiness in qualitative research is used as a test of rigor to establish the integrity of the study (Polit & Beck, 2012). To guarantee academic rigor data collection was completed by the researcher, no research assistants were employed. In addition the researcher transcribed the audio recording and crossed checked the transcripts with the audio recordings. Transcripts were then copied to a CD and given to the research supervisor with the data analysis, chapter four, for review. The raw data, original transcripts, are included in the study as Annexure L.

Transferability refers to the extent to which the findings of one study can be applied to other situations, since findings of a qualitative study are specific to a small number of individuals (Polit & Beck, 2012; Shanton, 2004). To ensure transferability in this study, the researcher utilized the services of a variety of participants providing care to psychiatric patients in psychiatric clinics and hospitals. Chapter four provides a description of the sample (age, sex, educational background, working experiences, cultural background, and religious affiliation) and a detailed but simple description of research findings so that the reader will evaluate the applicability of these findings to other settings. Within this chapter is a description of the hospital taking part in the study and where it is based; type and number of participants involved;

data collection methods; number and length of data collection sessions and period over which the data were collected (Polit & Beck, 2012; Shanton, 2004).

Credibility of the study refers to the confidence in the truth of the data and in the interpretation of the data by the researcher (Polit & Beck, 2012). Credibility can be enhanced by triangulation, member checking and thick description (Holloway & Wheeler, 1996; Polit & Beck, 2012). To ensure credibility and confirmability of the data, the researcher continuously listened to the interviews and compared them to the verbatim transcripts to ensure that both were saying and meaning the same (prolonged engagement). Also, the researcher, through peer debriefing (structured group research supervision sessions facilitated by the research supervisor) discussed the process of data analysis at regular intervals. In addition the researcher employed triangulation.

Triangulation refers to the use of multiple references to draw conclusions about what constitutes the truth, in order to overcome bias and capture a more complete and contextualized portrait of phenomenon under study (Brink, 2006; Polit & Beck, 2012). To ensure that triangulation the researcher applied method triangulation to collect data, by interviewing and reviewing documents containing policies/guidelines of advanced nursing practice. These included activity book, in-service education book used at the hospital. Method triangulation allowed for meaning and understanding to be established from various sources as they emerged, mutually enriching each method and providing a depth of understanding so as to converge an accurate representation of reality of the nature of role of the advance practice nurse, that could not be achieved through the use of only one method (Burns & Grove, 2009; Polit & Beck, 2012). In addition, the researcher applied time triangulation by collecting data with the some of the same participants four days after the initial focus groups to determine the congruence of phenomenon across time (Polit & Beck, 2012).

Member checking, as a form of triangulation, included the researcher communicating with study participants themes emerging from the data analysis and the researcher's conclusions allowing the participants to validate emergent themes or not (Polit & Beck, 2012). Member checking occurred at the end the focus group discussion after four days. Participants were specifically

asked to provide their opinions on the thick descriptions to ensure that were true presentation of their actions. *Thick description* refers to detailed description of the interpretation of data that was collected, includes complexities, variabilitys and commonalities (Polit & Beck, 2012). Interpretations included variabilitys under varying contexts within the hospital setting. In addition, chapter four and five provide results and discussion of the transactions. This provides sufficient information for judgment about the context under which the study was conducted. To ensure further academic rigor, matching interview guide questions, document review checklist against study objectives and conceptual framework were done.

To ensure dependability, the researcher documented all the raw data including the field notes and interview transcripts, methods and sources of data generation and analysis decision (Polit & Beck, 2012). By reading the audit trail another researcher should be able to arrive at comparable conclusions given the same setting (Gillis & Johnson, 2002). *Confirmability* refers to the objectivity or neutrality of data so that two independent researchers would agree with the meanings emerging from the data (Gillis & Johnson, 2002). The researcher listened to the focus group interviews and compared them to verbatim transcripts to ensure that both were saying and meaning the same. To ensure bracketing the researcher explored own values and beliefs regarding the role of the APPN through journaling and discussion with colleagues not participating in the study. The researcher realized that as an APPN there were expectations and, to bracket this, the researcher explored these verbally with colleagues and used the audio recording to prevent manipulation of the meaning of the phenomenon as explained by the participants that could occur with written records (Brink & Wood, 2000). In addition, the research supervisor acted as a co coder of the raw data.

3.10. ETHICAL CONSIDERATIONS

Ethical approval and gate keeper permission was sought for the study. The research proposal was submitted after presentation and approval by the School of Nursing, to the ethics committee at UKZN (Annexure: F). As soon as approval was received from the UKZN ethics committee, a letter accompanied by the research proposal was sent to the Provincial Department of Health for approval to conduct the study(Annexure: D). A letter of permission was written to the

Management of the hospital then to the Ethics committee of the psychiatric facility to conduct the study at their hospital (Annexure: A). *Gate keeper engagement* was achieved through meeting with the management initially to present the study to ensure that MHCUs quality of care was not going to be jeopardized. After the presentation the management was given a copy of the proposal to read at their leisure.

In reviewing *the risk benefit ratio* the risk to participants was minimized. The participants' rights to full disclosure was addressed by an information and consent sheet (Annexure: C & G) that outlined the purpose of the study, the procedure for data collection, and how information from the study would be disseminated. In addition the group meeting with all potential participants, described in point 3.7., page 32, also facilitated full disclosure and reduction of risk for participants.

Respect for Autonomy was achieved by the selection of the participants being done on a strictly voluntary basis. Participants had freedom of choice to participate or not to participate, and the right to withdraw at any time, if they so wished. Participants were made aware of this right through the information document (Annexure: C).

Confidentiality and Anonymity were actively pursued and discussed with participants. The data that was collected was treated with confidentiality and kept under lock and key. It was only accessible to the researcher and the research supervisor. The researcher interviewed the participants in a private and quiet place of their choice, in order to maintain privacy. A note was placed on the door informing people that an interview was in progress, in an attempt to prevent interruptions. Pseudonyms names were used so that whatever they said was not connected to any real names. The researcher explained to the group that confidentiality could not be assured within the group but reminded the group of the reasons for confidentiality and requested that they keep all content from the focus group and membership of the focus group confidential.

3.11. DATA MANAGEMENT

Hard copy biographical data and transcribed interviews were stored in a locked cupboard in the researcher's place of residence. This data will remain stored for five years. The researcher made use of a private computer to which only she had access. Identified names and places were removed from transcribed transcripts. The audio-cassettes were stored in a locked cupboard and will continue to be stored in a locked cupboard in the supervisor's office for two years if the result of the study is published and for five years if no publication results from this study before being destroyed.

3.12. DATA DISSEMINATION

The examined and corrected report will be bound and submitted to the library of the University of KwaZulu-Natal. The completed study will be prepared with the supervisor, for publication in an accredited nursing journal.

3.13. SUMMARY OF THE CHAPTER

In this chapter the research methodology was presented in keeping with exploration as the chosen design. The chapter further pays specific attention to the processes of sample selection, data collection and the steps of data analysis. Measures to meet the ethical requirements for the study, including academic rigor were presented to avoid errors of conclusion and interpretation of the data.

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.1. INTRODUCTION

This chapter presents the analyzed data. The qualitative research design which was used to collect data focuses on the subjective feelings of participants about the topic under discussion, the advance psychiatric nurse practitioner's role in the provision of health care in a psychiatric hospital (Mouton, 2001). The presentation of the results elaborates on the demographics of the participants and the categories as per the interview guide, the data analysis process and the themes that emerged from these categories. Verbatim quotations from the transcribed interview are included to illustrate.

4.2. DESCRIPTION OF PARTICIPANTS AND THEIR WORK SETTINGS

Participants included twelve (n=12) APPNs who had completed the Advanced Mental Health Nursing Certificate under the SANC regulation R212, and five (5) managers involved in the selection of nursing staff to be granted time to enter into the above mentioned certificate program on a part-time basis.

The demographics of participating APPNs, outlined in table 4.1.), included age, gender, race group, work experience and job title. Participants ages fell into three categories; 25-35years (n=4, 33 %), 36-45 years (n=7, 58%) and 46-60 years (n=1, 9 %). Gender distribution within the APPN group was three males (n=3, 25%) and nine females (n=9, 75 %). Race groups included black African (n=2, 17% %), Indian (eleven=9, 75%) and white (n=1, 8%). As described in Chapter three (point 3.7., page 33) participating APPNs were working in various wards in this specialized psychiatric hospital: child and adolescent unit (3 participants); acute units (6 participants); and psychogeriatric units (3 participants). There was a wealth of psychiatric nursing work experience among participants ranging from three (3) years to seventeen (17) years, the majority of participants (n=10, 83%) having 10 or more years of psychiatric nursing

experience. Experience post completion of the advanced certificate program ranged from 10 months to five and a half years. The majority of participants (n=8, 66%) having more than two years of practice as an APPN.

Table: 4.1 APPN DEMOGRAPHIC DATA

Participant No	Age	Gender	Race	Working Experience	Work experience post certificate	Job Title
1.	36-45	M	B	12 years	5½ yrs.	Operational Manager
2.	25-35	M	I	10 years	5½ yrs.	Operational Manager
3.	36-45	F	I	10 years	6 yrs.	Senior Prof/nurse
4.	25-35	M	I	4 years	10 months	Operational Manager
5.	36-45	F	I	15 years	10 months	Operational Manager
6.	25-35	F	I	10 years	2 yrs.	Senior prof/nurse
7.	25-35	F	I	10 years	10months	Operational Manager
8.	36-45	F	I	51/2 years	1 yr.	Operational Manager
9.	46-60	F	W	25 years	5½ yrs.	Operational Manager
10.	36-45	F	I	16 years	3½ yrs.	Operational Manager
11.	36-45	F	I	17 years	4 yrs.	Operational Manager
12.	36-45	F	B	15 years	3 yrs.	Operational Manager

Participating APPNs belonged to two categories of job title; operational manager and senior professional nurse. For clarity of the job titles definitions are given. Firstly, a senior professional nurse is a registered psychiatric nurse who has been translated to the rank in recognition of years of experience. This registered nurse is usually the deputy of the operational manager and is hands on with the care of the MHCUs. Secondly, an operational manager is the registered nurse who is in-charge of a unit, core functions include administration duties related to the day to day functioning of the unit, delegation and supervision of staff members.

The second participant group, managers, included five (n=5) participants. The demographic data for these participants is represented in table 4.2. participant's ages encompassed two age groups only; 36-45 years (n=1, 20%) and 46-50 years (n=4, 80%). Gender distribution within this group was one male (n= 1, 20 %) and four females (n=4, 80 %). Race groups included black African

(n=4, 80 %) and white (n=1, 20%). Work experience within mental health / psychiatric health care ranged from seventeen (17) to twenty six (26) years.

TABLE: 4.2 MANAGEMENT DEMOGRAPHIC DATA

Participant No	Age	Gender	Race	Working Experience	Job Title
1	46-50	F	B	22 years	Assistant Manager Nursing
2	46-60	F	W	26 years	Prof/nurse- in-service training
3	36-45	F	B	17 years	Assistant Manager Nursing
4	46-60	M	B	22 years	Assistant Manager Nursing
4	46-60	F	B	17 years	Assistant Manager Nursing

Two job titles were reflected in the managerial participants; assistant manager nursing and professional nurse in-service training. The assistant managers nursing are those registered nurses who work in the matron’s office and form part of the senior management. They are in charge of a group of wards. The professional nurse in-service training is the professional nurse whose responsibilities include learners, their orientation and in-service training. She also conducts in-service training and workshops for the hospital staff members. She monitors the progress of staff members seconded for training at different institutions

4.3. BRAUN AND CLARK’S METHOD OF DATA ANALYSIS

As stated briefly in chapter three the data was analyzed using the process outlined by Braun and Clarke (2006). The steps in this process included: familiarizing self with the data; generating initial codes; searching for themes; reviewing themes identified and defining and naming the themes; producing the report.

4.3.1. Familiarizing self with the data and generating initial codes

The researcher listened to the focus group discussions on the audio tape recorder whilst she typed the notes on the computer. The researcher then listened to the audio tapes while reading the electronic version to check for accuracy. The researcher then engaged herself with reading and

re-reading an electronic version of each transcript to identify the statements and phrases which expressed the participant's perceptions of the phenomenon. These statements were italicized and in brackets the researcher highlighted using different colors to identify the emergent codes. This process enabled the researcher to re-read the italicized statements and thus to focus on identifying the initial codes. A copy of each or the raw data from each focus group can be found as annexure L.

4.3.2. Searching for codes

From the transcribed interviews, several themes emerged, by looking at common narrations across focus groups. Only content that related to emergent themes relevant to the study objectives were grouped together (Polit & Beck, 2012). The researcher specifically looking at the content that related to the three study objectives. The content was read and analyzed according to potential relevance to each study objective. The researcher asked herself two basic questions "what information was embedded" and "how was the information embedded" so as to analyze the meaning of participants statements. The researcher asked herself if statements related to study objectives. For example, what is the meaning of the statements? Is the content related to how the participants are practicing as APPN or as professional nurses working in a psychiatric ward? This was essential as Creswell (2007) suggests that these questions are useful for novice qualitative researchers in formulating meanings. A copy of the emergent themes can be found on section hereunder.

4.3.3. Reviewing themes identified and defining and naming themes

The revision of the themes was done with the research supervisor and emergent themes were defined and named, changing the list of emergent themes previously achieved to incorporate regrouped emergent themes into the following: one dimensional role, collaboration, model of care, educational preparation and update, expectations, scope of practice/practice guidelines, the controversy of the occupational specific dispensation and lack of organizational support.

4.1.1 Theme 1: ONE DIMENSIONAL ROLE

From the demographic data it is clear that the majority (n=10; 88%) of APPNs were operational managers tasked with the management of the unit. This managerial position seemed to be directly linked to an emergent theme of clinical specialist versus managerial role. Despite the assertion in current literature that APPNs function in a variety of roles (clinical care, administration / management, nursing consultation and education) participants in this study perceived themselves as functioning in one role only (Bryant-Lukosius & DiCenso, 2004; Bryant-Lukosius et al.,2004; Gardner et al.,2007; Hanson & Hamric,2003; Mantzoukas & Watkinson, 2007; Rapp, 2003). Both the APPNs who were not operational managers and the APPNs who were operational managers perceived the operational manager as not practicing as APPNs.

Non-operational manager: *“They (the APPNs who are operational managers) do not really use their advanced skills because they are always running meetings”.*

Operational manager participants echoed this sentiment:

“Well for me the morning is mainly administration because I form part of management. After that I delegate duties There is lot of meetings that we have to attend from time to time..... you find that the person who is with the patients most of the time is other staff members who do not have advance psychiatry. most of us we ended up here in the management positions where we still have to do admin responsibilities which cut into the time that you could dedicate to working as an advance practitioner”

4.1.2 Theme 2: COLLABORATION

Currents authors stress that one of the main functions of a nurse leader is collaborating with other nurses and healthcare workers in the delivery of patient care (Brant-Lukosius et al, 2004; Bryant-Lukosius & DiCenso, 2004; Furlong & Smith 2005; Jones, 2005; Sullivan & Decker, 2000). A second emergent theme related to decision making and collaboration amongst mental health care

practitioners (MHCP). Meads and Ashcroft (2005) suggest that great hopes are currently pinned on improving the quality of public health and healthcare through inter-professional collaboration. Current literature suggests that the foundational components of collaboration involve, but are not limited to, mutual respect and trust; regular dialogue between team members; mutual problem identification; commonly defined mission, vision, and values; compatible practice philosophies and objectives; regular team education; adequate support (external and internal); shared decision making; openness to learning from the expertise of others; and appropriate reward as well as recognition systems (Baggs, 2005, Gardner & Gardner, 2005; Hogan & Shatell, 2007). Some of these characteristics are visible in participant's perceptions, specifically respect and trust, regular and mutual problem identification. Participants responded to questions about the level of decision making as a team effort, the collaborative process linked to individual role players and established relationships within the team, specifically with medical officers.

“We sit together and make decisions regarding patient care”. “We actually sit together and solve problem regarding patient care. I think it is largely dependent on who you have in your ward at a given time”.

“We are fortunate that we have had our M.O. (medical officer) there for a very long time and we have built a relationship. It does become hard with the changes with the staff when they come and go”.

A comment specific to relationships, the lack of *“Sometimes we get the doctors who do not understand what the nurses go through and have expectations and those that feel that you are putting your nose into their domain”.*

Some participants felt that they are undermined by other health care professionals and this affected their decisions about implementation of health care project as evidenced in the following statements.

“Not really but what I picked up in this ward is that sometimes a person will start a group and it sort falls on the wayside or someone come and takes over and I feel that’s what put people off from running the groups”.

Some participants felt that the additional qualification (advanced mental health nurse) facilitated a more active collaboration

“I think he (the medical officer) has learnt to trust us because now that we have done advanced psychiatry we are more knowledgeable and we give valuable input to the MDT (Multidisciplinary team)” “Our input is valued more now than it was previously”.

4.1.3 Theme 3: MODEL OF CARE

The biomedical model is predominantly utilized in the management of MHCUs in this psychiatric hospital. As in any change process, the use of a psychosocial model is faced with resistance from other health professionals, the shift towards the use a psychosocial model is a slow and retarded one. Several authors argue that comprehensive approach to mental illness is just lip service for most of the physicians as they prefer the use of medication as their first line therapy (Gill & Hough, 2007; Golstein, 2007). Most participants when asked about the model of care used confirmed a biomedical approach to care.

“It’s the Biomedical. We are though trying to shift but haven’t made much progress”.

“It’s is the doctor’s mind-set that we are using mainly the biomedical model. I think they can’t just shift”.

All is not lost though since in some wards the staff members were using the psychosocial model as evidenced by this excerpt:

“In our ward we use both the biomedical and the psychosocial model. when they come in the first week whatever medication they are on from the out-patient department or from the private doctors in this ward we stop all medication to get the true reflection of the client and after that if there is a need we put them on to medication but most often you will find that they don’t even need medication. We have two children who were on medication but we have not put them back because they don’t need it”.

The bio-psychosocial model focuses on the integrative, dimensional approaches in medicine, prevention as well as emphasizing the patient’s role as knowledgeable active member of the health team. This model assesses attitudes, behaviors and emotions both individually and relationally. This model also advocates that researchers should assess medical, physiological and cultural factors in understanding and treating health and mental health problems (Gill & Hough, 2007; Golstein, 2007). This model seemed to be alluded to by this participant.

“We also focus a lot on the psychosocial model. We focus on their behavior…….”
“They do not want to talk about their things. We ask them to draw pictures and a lot of pictures will tell you a story even about abuse. So yah I will say both biomedical and psychosocial models”.

4.1.4 Theme 4: EDUCATIONAL PREPERATION AND UPDATE

In this emergent theme data related to undergraduate programs and the advanced mental health nursing program as well as resources to remain up to date.

Khoza and Ehlers (2008) pointed out that some professional nurses in SA perceived the newly qualified nurses in psychiatric units to be making blunders every day, always under the umbrella of their seniors and that MHCUs were not safe in their care. Girot (2000) reported that registered nurses in England commented that newly qualified graduates knew nothing and expected to be ‘spoon fed all the way’. The perceptions in these studies are supported by data in this research study. In addition to the shortage of staff, participants complained that they have the added

responsibility to nurture and guide the professional nurses from the four (4) year undergraduate programme (SANC, R425). They felt that the psychiatric module of this course does not prepare these professional nurses to manage MHCUs effectively. This is a great concern as the wards are inundated with these professional nurses doing their community service obligation.

“It very difficult because the psychiatric nurses are coming from a four year context where there is no solid foundation into mental health. They do not have experience and that intuitiveness You need people who understand mental illness thoroughly who has a good concept of aggressive patients, what aggression is about, where it is coming from and suicide. They can do the basics but even then they are haphazard in their performance”.

Regarding the advanced mental health nursing course, participants felt that earlier graduates were not at the same level of knowledge and understanding amongst themselves as APPNs. The general consensus was that APPNs who attended the course when it initially started are not as “clued up” or as knowledgeable as the APPNs who completed the course more recently. According to them, the curriculum has evolved and includes a lot of new innovations related to knowledge and skill content. They suggest that it is crucial for members to be up-dated from time to time with new developments in psychiatry. Within the literature, several authors argue that knowledge and skills gained after graduating decreases within 1 year; therefore they suggest that a refresher course may be required prior to the end of the usual 2 year certification period, preferably at 1 year after the course (Duran, Aladya, Vatansaver, Kucukugurlogly, Sut & Anucas, 2008; McCluskey & Lovarini, 2005). This is captured well in the following excerpt:

“The newly qualified registered nurses are (more) knowledgeable than us who studies donkey years ago. We would like to have an update so that we are on par with the recently trained advanced practitioners”.

These results are congruent with previous study results that suggest that performance (skill performance and knowledge recall) deteriorates as more time elapses since the initial training, regardless of the amount of training (Duran et al., 2008; McCluskey & Lovarini, 2005).

In addition to study participant's perceptions of their need of in-service training or updating, participants also made specific reference to lack of resources, human and technical. Participants saw role models as necessary to updating and continued involvement of their practice as APPN;

“If we had a group of advanced practitioners that was functioning, this will work but we have nothing to look at, we have no benchmark”.

Role models are reported extensively to be useful for novice APN (Bamford & Gibson, 2000; McCluskey & Lovarini, 2005). These authors argue that the lack of suitable role models hinders occupational socialization. In addition participants directly referred to the lack of technology as a hindrance in their practice;

“I think its lack of resources because even if you want to do something e.g. search for data using the internet, there are no computers. Sometimes even if you want to do lectures it is difficult to look for information or to download it when you want to do in-service. It's simple things like that that actually can become a problem”.

The participants put the blame primarily on management for not providing equipment or ensuring that the staff members have equipment to conduct research. According and Hau (2004) the lack of resources is one of the factors that impact on the relationship between nurses and management. While nurses are interested in improving the quality of service, the goal of management is on how to cut cost. This is echoed by the following excerpt;

“The management does not understand the need for having computers in each ward to do research, they only think that we want the computer to play games and they only think that internet is expensive”.

Management participants' comments in this area were captured in the following statements:

“Well shortage of resource is a big problem but we are trying all we can to make motivation to get more equipment”. “We do support the staff members it's just that

they don't make their requisition on time because you see these things involve cash flow decisions."

The APPN are concerned about lack of resources to do their projects. They blame the management about their perceived lack of support. The management is singing another tune. They feel that they do provide support: This they had to say when asked about the support:

"I would say they are given support because if they are giving a request in writing and writing down whatever motivation and the programme that they want to run, it has never been turn down because we need to see the way forward". This was further eluded by this participant: "I believe that anything that they would come up with that they would like that is proactive would be happily welcomed and supported by management but at the moment I have not seen any request"

4.1.5 Theme 5: EXPECTATIONS, SCOPE OF PRACTICE / PRACTICE GUIDELINES

The absence of scope of practice is a major concern for participating APPNs. They reported no clear guidelines of what they are supposed to be doing with the result they are performing mainly as the customary psychiatric nurse. Participants generally agreed that they were not functioning as they believed an APPN should. When this was explored comments related to barriers, specifically managements lack of a job description that highlights their lack of understanding and support.

"One of the biggest barriers is that there is no real scope of practice, we do not know what to do..... what exactly is really expected from me. I did go to Howard Campus (University of KwaZulu-Natal in Durban); I got the knowledge but sometimes you can't practice it over here. If we have a scope of practice to tell us this is how we differ from the ordinary psychiatric nurse maybe that will be better because right now we just practicing just like a normal registered psychiatric nurse".

The lack of hospital guidelines or policies which guide the practice of the APPN was frustrating for the APPN. They were expected to do more yet more was not explained clearly to them;

“I think that there is a lack of knowledge on the management side about what advance psychiatry is and what we should be doing. I think management think that advanced psychiatry is just doing psychosocial rehabilitation (PSR). That makes me feel frustrated and demotivated. You know we need the management to do it so they will understand what needs to be done. Otherwise you will always have a stumbling block. Unless they do it there is no hope”.

Participants from the management groups expressed expectations regarding the APPN performance. These participants expected APPNs to develop and manage projects related to MHCU care and capacity building amongst the nurses:

“I expect the advance nurse practitioner to be able to develop programmes specific to the patients that they are nursing, depending on the type of patients. I should think its strong leadership skills. As they have been to Howard (University of KwaZulu-Natal, Howard College Campus) through the advanced training therefore I would expect them to take a leadership role in the ward and patient care and patient management”. “They should be able to develop programmes and also be able to demonstrate a very strong teaching role in the wards because of their increased knowledge and broader knowledge range gained, they really be teaching the other staff and helping them to expand their knowledge”.

At the same time management participants acknowledged a lack of scope of guidance for the APPNs within the institution.

“There are no indicators or tools which guide the nurses about their performance”.

The challenge is the lack of hospital guidelines or policies which guide the practice of the APPN. It is frustrating for the APPN to be expected to do more when more is not explained clearly. In a study by Jones (2005) most stakeholders were unclear about the objectives, individual responsibilities and anticipated outcomes of the APN roles. Lack of clarity concerning the roles and tasks expected of nurses working in advanced roles may lead to increased work-related stress, uncertainty about the extent of responsibility, resulting in poor performance (Carr, Bethea & Hancock, 2001; Marsden & Street, 2004; Rosen & Mountford, 2002).

APPN participants made direct reference to their capacity building role and three main barriers were reported as not facilitating this role; lack of educational resources, staff rotation policy and staff shortages.

Firstly, the lack of educational resources that facilitate their own development and ability to keep up to date is perceived as impacting on their ability to build capacity:

“..... research is a problem, we need to teach the general stream professional nurses (PN) how to conduct some of the assessments”.

Secondly, briefly, staff rotation is defined as a reciprocal exchange of staff between two or more clinical areas for a predetermined period of time (Richardson, Douglas, Shuttler & Hagland, 2003). Participant's main concern was that they train nurses about the modern and innovative assessment methods only to find that the APPN or the newly trained nurses they - are rotated to other wards. They disliked training new staff all the time and felt that their APPN qualification forced them to accept being moved to new environments against their wishes. They considered the change to new environments as stressful and they perceived this as a reason why staff resign from the institution;

“Rotation of staff, I think this is our main concern. We orientate the staff and teach them everything only to find that they rotated and new staff comes. The continuity of nursing care is disturbed. Then you find new staff with resistance and whatever you do it's like starting all over again because everybody is gone”.

Staff rotation is acknowledged in the literature as having operational and managerial issues, specifically a lack of opportunity to supervise properly (Richardson et al., 2003; Evans, 2001; Duffy, 2001). Clearly the rotation of staff was a sore point for participating APPNs as reflected in the following statement;

“What we have found is that because of the rotation of staff we fall back on the programme because we have to re-teach the same thing all over again”. “You have to again get people to buy in. In terms of support this is the area where we really lacking”

“I think it’s not about starting the programme but about sustaining it, because you will start a programme and you find other thing filtering into it then it becomes very difficult to sustain it. Like lack of interest from the staff members, frequent rotation of staff”, “It’s by allocation; our zone matron allocated us to whichever ward”. “We work in the ward for a few months and you are rotated constantly”, “Same the matron’s office does the allocation I had no choice I was just allocated”.

Lastly, the shortage of staff. The shortage of health workforce is an international and national phenomenon. The sources quoting a nursing shortage in SA are abundant and varied (McGrath, 2004; Buchan 2002; Jensen & Aamodt, 2002; Goodin, 2003; Mee & Robinson, 2003; Ross, Rink & Furne, 2000; Duffield & O’Brien-Pallas, 2003; Armstrong, 2004). Participating APPNs verbalized a shortage of staff in general as a barrier to their role implementation.

“Here in this ward the plan is to do assessment of the patients and put them into different programmes, but it takes like one person just to that only, leaving out the doctor’s round medications, groups, meetings etc. So the shortage of staff and the lack of staff with advanced training is a major challenge”.

As is clear in the previous participants verbalization, APPNs were also concerned with the lack of APPN throughout the institution, the result being that an APPN is not part of the team on each and every shift with frustrating consequences;

“As an advance practitioner it is difficult to sustain whatever you start. Most wards have minimum of two APPN and that’s if you are lucky. So it’s very hard to find that person who will run the daily routine and all the things that filter into the day plus do the projects”.

Work overload limits the practitioner’s activities and because of time pressures the clinical workload always takes priority over the other components of the APN. Research for example has to be done in the APN’s own time (McCreddie, 2001). Increasing workloads impinge on the APPN core communicator’s career role and potentially restrict the innovator role causing stress and potential burnout. Nurses feel that they are overworked as it is and they view implementation of the APPN role as an additional function. This is what one of the participants had to say:

“To still steer the people who are trained with just psychiatry we need people with advance psychiatry to co-ordinate and put the programmes together and be that people who is steering and leading the projects”.

4.1.6 Theme 6: THE CONTROVESY OF THE OCCUPATIONAL SPECIFIC DISPENSATION

BRIEF DESCRIPTION OF OSD

The Occupational Specific Dispensation (OSD) was introduced by the Government in September 2007. The intention behind this move is to improve government’s ability to attract and retain skilled employees through improved remuneration. The implementation of the OSD put in place a proper career-pathing model for all occupational categories. Such a career-pathing model is not an automatic salary increase but a forward planning framework to systematically increase

salaries after predetermined periods based on specific criteria such as performance, qualification, scope of work and experience (Fouché, 2007).

The implementation of the Occupational Specific Dispensation (OSD) is suggested to have contributed to role ambiguity and negative attitudes of staff, specifically between APPNs and psychiatric nurses. The OSD, though introduced with great intent has become a bitter pill for those who did not benefit from it. The following excerpts point this clearly:

“There are not many of us with advance psychiatry so it’s difficult to do some project and other Professional nurses feel you have the qualification so you must do the job”. “Like in my ward I am the only one who has advanced psychiatry and to get people to change it’s difficult. What makes it worse is the OSD one will find out two professional nurses will be at the same level academically and not financially. And this has created a lot of problems. It becomes a problem as to who takes charge and who is responsible for what? This becomes an area of conflict”.

“It feels like a loss because it feels like you are studying for nothing. One of the reasons for doing advance psyche is because I wanted to prosper. I have been working here for 16 years and it feels like I am going nowhere. When they have interviews you are not one of the people that are selected. Sometimes you are not even motivated to do the groups because you feel that they got the job, they must run the group.”

The participants displayed a lot of anger and resentment as they are not remunerated and this is causing a lot of frustration for the professional nurses.

“I used to sacrifice my Saturdays, paid so much of money to study, I used to sign leave and go on my days off to go and study the advanced psychiatry and when we came back we are not recognized. We were not compensated or paid any money for it. Sometimes you even wonder if it is worth it because when we came back the other staff members was laughing at us saying we fool and we wasted our money

and we are not different to anybody else and it's not even worth it. All the girls are not going to do advanced psychiatry because OSD has already been given and having advance psychiatry does not make a difference.

These responses are not in favour of the MHCUs and health care because research has shown that employees who are not satisfied at work usually do not give their best (Joyce, 2010).

4.1.7 Theme 7: ORGANIZATIONAL SUPPORT

There is perceived lack of support from the management. The participants are expected to produce high level of care without the relevant tools to do that. Management claim to be supportive to the APPN but the sentiment is not shared by the APPN. This following excerpt captures this lucidly

“It all depends on the change that you will want to effect. I think they try but they could be more. It also depends on the project because you are told you have the skills now just go and do whatever you are planning to do. I think you have more the permission than the support, because the support that you get is limited. How can you perform without resources?”

The lack of management support has resulted in the staff members not working as they are supposed to in their departments. This view is also shared by Jones (2005) who argues that organizational support is crucial as its absence can delay change and impact adversely upon the ability of the APPN to set realistic work targets. Advanced nurse practice is unlikely to flourish unless the employing institution values clinical expertise, displaying a demonstrable willingness to allow advanced practice nurses to practice and to update knowledge and skills. The other concern was that the management has no idea of what an advanced practice role entails. They have too many expectations without providing clear guidelines for performance.

“I think we need support so that when you come up with programmes we get support. I think also that our management is not sure of what we as advanced

psychiatric practitioners are supposed to be doing. That is why we do not get much support. We initiate the programmes but if you do not get support you cannot progress. We need policies, we need a scope of practice and we need guidelines and we would be able to function more effectively”.

Advanced nursing practice is unlikely to flourish unless the employing institution values clinical expertise, displaying a demonstrable willingness to allow advanced practice nurses to practice and to update knowledge and skills (Callaghan, 2007; Lloyd Jones, 2004)

SUMMARY

This chapter discussed the findings, the APPN and the nurse manager’s demographic data, perceptions of the advance psychiatric nurse practitioner’s role in the provision of health care in a psychiatric hospital at uMgungundlovu district, challenges they encounter in the facilitation and implementation of the APPN role. The researcher gave a detailed process involved in data analysis to ensure trustworthiness of this study.

CHAPTER FIVE

DISCUSSION AND RECOMMENDATIONS

5.1. INTRODUCTION

This chapter focuses on the discussion and is related to the study objectives. Discussion related to objective three is presented after objective one for readability; this is then followed by objective two. Thereafter, issues encountered by the researcher in the process of bracketing are discussed in the section entitled "researcher reflexivity and limitations". The chapter concludes with recommendations for psychiatric nursing practice, nursing policy makers, nursing education, nursing research summary and then conclusion.

5.2. DISCUSSION

5.2.1. DESIRABLE KNOWLEDGE AND SKILL

The first objective was to describe participant's perceptions of the level of knowledge and skill that the APPN should possess. Current literature suggests that the APN is a specialist level practitioner who has successfully completed advance education that has provided the tools for the APN to engage in clinical practice, research, teaching and consultation, and leadership (Callaghan, 2007; De Geest et al., 2006; Pearson & Peels, 2002). It was evident from the focus group discussions that all participants, APPNs and management, perceptions were in agreement with current literature regarding desirable skills and knowledge. Despite this, participating APPNs and management clearly did not perceive the APPNs as exhibiting this level of knowledge and skill.

All the participating APPNs completed their advanced course at the same institution and a review of the APPN course objectives, curriculum content and course overview suggests the development of clinical skills, academic skills and a focus on change management are core competencies of the course. It is relevant to note that academic skills included in the course focus

on using electronic data basis (many with open access) to search the literature, critically reviewing research articles and establish best practice benchmarks. Despite participating APPNs acknowledging the existence of these skills and knowledge they reported specific barriers to their implementation. The four main perceived barriers to their (APPN) functionality were; lack of internet access at the worksite, the staff rotation policy, administrative responsibilities and a perceived lack of role models. Participating APPNs suggested that the eradication of these barriers was a managerial responsibility.

5.2.2. FACILITATING THE IMPLEMENTATION OF THE APPN ROLE

The third objective for the study was to describe processes instituted to facilitate the implementation of the APPN role in provision of health care and will be discussed in relation to the four main barriers reported by participating APPNs.

The researcher investigated the hospital environment and policies to discover that although each unit did not have internet access, there was access at a nursing educational centre on the hospital grounds.

The staff rotation policy was reviewed by the researcher and outlined the rotation of staff, other than the operational managers who are not rotated, on a three to six monthly basis. This policy aimed at facilitating management's objective of APPNs building capacity throughout the nursing staff population. This policy perceived by participating APPNs as a barrier was described by management as a facilitator of implementation of the APPN role, specifically the teaching consultation role.

The issue of administrative responsibilities of the APPNs is linked to the national and local implementation of the OSD. The researcher proposes that the implementation of the OSD is itself a core barrier to realizing not only management's expectation of APPNs but also professional hopes. As briefly presented in chapter 3 in the description of the research setting, page, 31 the introduction of the OSD had good intentions regarding the retention and motivation of essential service staff, specifically nurses. Anecdotal data suggests that since the introduction

of the OSD there has been a dramatic increase in application to complete the advance psychiatric course. However the implementation of the OSD document within various work settings, specifically psychiatric hospitals and services, has resulted in frustration, anger and resentment between nursing colleagues. The implementation in these settings has created a post related advancement system where APPN remuneration is attached to operational managerial positions. APPNs who are not operational managers clearly resent this situation and this is suggested to impact on their willingness to engage with and embrace APPN roles. In addition, although the management selection committee determines who receives permission to study part time the institution does not support the applicants financially. This is a permission process not a secondment process. The result of all these factors being that participating APPNs, not in operational manager's posts, felt that management has no claim to their expertise, they did not feel obligated to use their skills and knowledge for the benefit of the institution.

Clearly although persons received knowledge and skills through study there is no guarantee that such will be implemented in the work situation (McCluskey & Lovarini, 2005). The APPNs have been empowered with new skills and knowledge but there was limited evidence of their implementation. The very human motivation for financial gain seems to be of primary importance to participating APPNs and it is suggested that APPN perceived barriers to role implementation are less important than financial remuneration and recognition.

Those APPNs, who do benefit from the OSD, hold operational manager positions, are also not in favour of the post related advancement system. As reported in chapter 3, page 54, these participants dislike the weighting of administrative duties that reduced time for implementation of advanced knowledge and skill in the clinical setting. This is echoed as several authors argue that nurses who are prepared in this advanced practice role may not be in position where they are available to meet or direct the nursing care needs and patient's safety (Mayo, Omery, Agocs-Scott, Khaghani, Moti, Redeemer, Voorhees, Gravell & Cuenca, 2010).

In summary although management perceived their actions to be facilitating the implementation of the APPNs role within the health care setting this seems to be not the case. It is suggested that the prospect of financial remuneration was, and continues, to motivate application to advance

mental health nursing courses and that this motivation is in most instances undermined by the OSD either because financial remuneration cannot be attained or once attained the APPN is primarily an administrator. This could result in non-utilization of the valuable skills which could enhance the quality of care rendered to the MHCUs. In addition, in the context where the SA nursing profession is struggling to put the APPN on the map, achieve recognition by the SANC, higher education, and other health care professionals it is suggested as important that the implementation of APPN roles is visible.

5.2.3. EXPECTED BENEFITS OF THE APPN ROLE

The second study objective was to describe the stakeholder's expectations of the positive impact that the APPN would have in the delivery of mental health / psychiatric care.

Current literature suggest that APN have proven to be beneficial in filling the gap in the health provision both in primary and acute health care settings (Kinnersley, et al, 2000; Horrock et al., 2002; Venning et al., 2000). In this study the APPN and the management are in agreement that there are no obvious benefits of the APPN that they can allude to. However, participating managers acknowledged that no indicators or tools were used to measure the effectiveness of the APPN in the provision of care. Although managers clearly had expectations of the APPNs related to health care outcomes these had not been formalized and no scope or guidelines were provided to APPNs that encompassed these expectations. There seemed to be a lack of communication between the APPNs and the nurse managers, neither having a forum to communicate expectations and concerns. This is line with the findings of Jones (2005) where he reported that most stakeholders were unclear about the objectives, individual responsibilities and anticipated outcomes of the APN roles. This has negative outcomes as lack of clarity concerning the roles and tasks expected of nurses working in advanced roles may lead to increased work-related stress resulting in poor performance (Rosen & Mountford, 2002).

The data suggests that the participating APPNs had not internalized advanced practice skills; specifically they have not acquired a sense of independence nor the leadership skills that could enable the APPN to determine their path and shape their position within the mental health care

setting nor within the nursing profession. It is suggested that this lack of independence and leadership is reflected in participating APPNs references to their need for role models. Walker (2008) suggests that nurses do not consider themselves to be experts in the areas in which they work. This is illustrated further in participant's descriptions of medical officers sanctioning their knowledge and skills before engaging them in collaborative team work, the APPN are dependent on the medical officer's approval of the APPNs contribution. These differential power positions further immobilizing the APPNs towards independent practice.

In conclusion, this is confusing to me because if a nurse has done the advance psychiatric course he/she needs to be an expert in her field of work. Therefore at that level the APPN does not require a role model instead they should mentor the newly qualified nurses to be valuable and efficient practitioners and fulfil their teaching function. This could be of benefit to them as ward duties will be done while they are busy with the managerial duties. The professional development of a nurse is an individual responsibility. It is appreciated that the APPN recognized the gap of knowledge between them. This could be achieved by on the job training, peer group teaching or in-service education by the recently trained APPN. The university could also be co-opted to do workshops with them. The APPN are perceived to be shifting the responsibility for the professional growth.

5.3. RESEARCHER REFLEXIVITY AND STUDY LIMITATIONS

Reflexivity is self-critical sympathetic introspection and the self-conscious analytical scrutiny of the self as researcher. (De Dreu, 2007). Indeed reflexivity is critical to the conduct of fieldwork as it induces self-discovery and can lead to insights and new hypotheses about the research questions. A more reflexive and flexible approach to fieldwork allows the researcher to be more open to any challenges to their theoretical position that fieldwork almost inevitably raises. Certainly a more reflexive geography must require careful consideration of the consequences of the interactions with those being investigated

As an advanced practitioner herself and working as an educator the researcher had often wondered how the APPNs were practicing in the psychiatric hospitals. The researcher undertook

the study with a view of exploring the development and implementation of the role of the APN in a psychiatric context. There was an enthusiastic response from the registered nurses since APNs are relatively new to the field of mental illness (Hayman-White, Happell, & Charleston, 2007). This motivated the researcher to have hope that the research study would facilitate participant reflection and assist to develop the APPNs practice, ultimately improving health care outcomes for MHCU. In addition the researcher hoped that participating APPNs would value their work and themselves as expert practitioners.

In reviewing the transcripts the researcher discovered that in the focus groups participants tended to follow one person, usually the first to answer, and respond with “*my response is the same as the first speaker*”. Despite participants volunteering, data saturation was reached after the third APPN focus group. The researcher experienced frustration at the continued repetition of information, specifically what seemed a desire to moan about management and an apparent lack of responsibility for their own practice development. The researcher continued with the focus groups, to honor participant’s initial agreements and did not comment on contributions despite this being difficult at times. The qualitative method is suggested to have been beneficial in that it allowed the researcher to observe attitudes, emotions, tone of voice, facial expressions which were beneficial in understanding the phenomenon clearly. In future the researcher would not issue an open invitation to participation but rather source a smaller number of key informants. The researcher is aware that the study participants may encompass only those APPNs who felt aggrieved and negative about their APPN role. This does not make the data irrelevant but it may illustrate a specific sub group of APPNs working in tertiary psychiatric hospitals.

The researcher believes that respect and dignity of the APPN will be earned through evidence of quality work achieved through commitment and dedication and had difficulty with the possibility that some participants focused on financial gains only, seeing this as a prerequisite to full implementation of skills and knowledge in practice. The researcher struggled with her concern that APPN participants’ references to specific barriers were *excuses to not function* as an APPN rather than *issues that prevent* the APPN from effective functioning. For example, skills and knowledge can be utilized to provide quality care despite not being provided with a specific scope of practice.

Throughout the process the researcher had access to her supervisor as bracketing was an on-going process. Specifically, before analyzing the data, in the final identification of themes and during the writing of the final report the researcher had discussions with the research supervisor that encouraged honest expression of frustrations.

Because the study used convenience sampling, the results cannot be generalized to other nurse populations. Although the sample was drawn from different wards, the sample was participant selected rather than researcher selected and as stated earlier this may not reflect the views and experiences of other APPNs.

5.4. RECOMMENDATIONS

5.4.1 IMPLICATIONS FOR NURSING PRACTICE

The strength and acceptability of these roles will depend on the ability of the profession to demonstrate competence and effectiveness of the APPN. This will assist to defend them against claims that the APPN are inferior alternative to conventional medical treatment. In the rural areas where there is a shortage of doctors the presence of the APPN will be of great benefit. Research has demonstrated that the level of educational preparation that the advanced practice nurses are exposed to is effective in the preparation for practice. This is relevant for mental health nursing since there are not an adequate number of psychiatrists to service those areas. Reflection of practice will hopefully assist the APPN to realize the gap in their practice and possibly enhance provision of quality care to MHCU

5.4.2 NURSING POLICY MAKERS

The South African Nursing Council has a challenge to speed up the process of regulating a scope of practice for the advanced psychiatric nurse practitioners. It is interesting though to note that the SANC in their draft position paper is recognizing that beyond nurse/midwife practitioner there is a need for advanced nurse (Nursing Act, 2005). The provision of the scope of practice will ensure that the APPNs are effectively used in their health care facilities thus ensuring quality care for the MHCUs.

5.4.3 NURSING EDUCATION

A curriculum which is inclusive of pharmacology needs to be developed. This will ensure that advanced psychiatric practice nurse that are produced have the prescriptive authority. Workshops should be held on a regular basis to update the APPN on the new development. A forum for the advance practice psychiatric nurses could be formed to address their educational needs, share information and research findings. A portfolio of evidence should be submitted yearly to the School of Nursing to monitor their effectiveness. The APPN could have peer group reviews where they will assess and monitor each other's effectiveness as APPN.

5.4.4 NURSING RESEARCH

The findings of this study will assist researchers to further advance the concept of advanced practice nursing and create new knowledge. A greater understanding of the conceptual basis of advanced practice nursing will help to gain clarity, external legitimacy and acceptance of the APPN roles by the society and other health care professions. Conceptualization advance practice nursing will enforce the links between knowledge development and nursing practice to ensure advanced practice nursing will reinforce the links between knowledge development and nursing practice to ensure advance practice nursing remains responsive to the needs of society. Agreement on the use and definition of fundamental terms of reference such as advanced practice nursing will assist in the evolution of the discipline. This universal meaning or

definition of advanced practice nursing will make it possible to compare, refine and develop advanced practice models.

5.5 SUMMARY

Several factors are at play that hinder the development and the implementation of the advance practitioner's role. These barriers are not insurmountable as they can be solved with simple measures like change of attitude for both the participants and the management. Flexibility when rendering care to MHCUs and positive approach can go a long way in facilitating effective utilization despite the shortage of resources.

5.6 CONCLUSION

Advance practice roles are still some way from becoming recognized roles within the health fraternity especially so within the mental health care field. This was supported by Jones and Minarik (2012) as they argued that if there were endangered species list for nursing practice, the psychiatric mental health clinical nurse specialist would surely be at the very top. The steady growth in these positions suggests that APPN will be an important component of the future workforce.

REFERENCES

- Armstrong, F. (2004). Can you hear us? There's a nursing shortage! *Australian Nursing Journal*. Vol.12, p. 21–24.
- Akinsola, H.A. (2001). Ethical issues in rural nursing practice in Botswana. *Nursing Ethics*. Vol. 8, No. 4, p. 340-347.
- Baggs, J. G. (2005). Overview and summary: Partnerships and collaboration –what skills are needed? *Online Journal of Issues in Nursing*. Vol.10, p. 16–19.
- Bamford, O. & Gibson, F. (2000). The clinical nurse specialist: perception of practising CNSs of their role and developments of needs. *Advancing Clinical Nursing*. Vol. 3, p. 282-292
- Benner, P. (1984). From novice to expert: Excellence and power in clinical nursing practice. Addison-Wesley publishing Company, California, USA.
- Bhengu, B.R. (2009). Nursing specialisation's impact on OSD and qualifications. *Health Annals*. 18th Publication of the Hospital Association of South Africa. P. 21-24.
- Boyd, C. (2000). Nurse practitioner and clinical nurse specialist: are the roles merging. *Clinical Nurse Specialist*. Vol.4, p. 78-84.
- Breier, B. (2007). The shortage of medical doctors in South Africa. Draft case study report forming part of the HSRC study: A multiple source identification and verification of scarce and critical skills in the South African labour market. Client report commissioned by the Department of Labour.
- Brink, H. (2006). Fundamentals of research methodology for health care professionals. 2nd edition. Cape Town: Landsdowner.
- Brink, PJ. & Wood, MJ. (2000). Advanced Design in Nursing Research. 2nd edition, California: Sage Publications.
- Brown S.J. (1998) a framework for advanced practice nursing. *Journal of Professional Nursing*. Vol. 14, p. 157-164.
- Bryant-Lukosius, D., DiCenso, A. (2004). A framework for the introduction and evaluation of advanced nursing roles. *Journal of Advanced Nursing*. .17, p. 205-213.
- Bryant-Lukosius, D., DiCenso, A., Browne, G. & Pinelli, J. (2004). Advanced practice roles: development, implementation and evaluation. *Journal of Advanced Nursing*. Vol. 48, p. 509-529.
- Buchan J. (2002). Global nursing shortage. *British Medical Journal*. Vol. 324, p. 751–752.

- Burns, N. & Grove, S.K. (2005). The practice of nursing research conduct, critique and utilization. United States of America: Elsevier.
- Burns, N. & Grove, S.K. (2001). The practice of nursing research conduct, critique and utilization. 4th edition, Philadelphia: WB Saunders.
- Burns, N. & Grove, S.K. (2009). The practice of nursing research conduct, critique and utilization. 6th edition, Philadelphia: WB Saunders.
- Callaghan, L. (2007). Advanced nursing practice: an idea whose time has come. *Journal of Advanced Nursing*. Vol.48, p. 530-540.
- Cameron A. & Masterson A. (2000). Managing the unmanageable. Nurse Executive Directors and new role developments in nursing. *Journal of Advanced Nursing*. Vol. 31, p. 1081–1088
- Carr, J., Bethea, J., Hancock, B., 2001. The attitudes of GPs towards the nurse- practitioner role. *British Journal of Community Nursing*. Vol. 6, No. 9, p. 444–481.
- Carroll, M. (2002). Advanced nursing practice. *Nursing standards*. Vol. 16, p. 33-35.
- Carryer, J., Gardner, G., Dunn, S., & Gardner, A. (2007). The role of the nurse practitioner: practice, professionalism and clinical leadership. *Journal of Clinical Nursing*. Vol. 16, p. 1818-1825.
- Clarke, A. (2000). Advanced nursing practice. *A BordAltranais news*. Vol. 12, p. 3-5.
- Coeling, H. V., & Cukr, P. L. (2000). Communication styles that promote perceptions of collaboration, quality, and nurse satisfaction. *Journal of Nursing Care Quality*. Vol.14, p. 63–74.
- Cornwell, C. & Chiverton, P. (2007). The psychiatric advanced practice nurse with prescriptive authority: role development, practice issues and outcome measurement. *Archives of Psychiatry*. Vol. 11, No. 2, p57-59.
- Cowan, M. J., Shapiro, M., Hays, R. D., Afifi, A., Vazirani, S., & Ward, C. R. (2006). The effect of a multidisciplinary hospitalist/physician and advanced practice nurse collaboration on hospital costs. *Journal of Nursing Administration*, 36, 79–85.
- Coyler, H.M. (2004). The construction and development of health professionals: where will it end? *Journal of Advanced Nursing*. Vol. 48, No. 4, p. 406-412.
- Creswell, J.W. (2007). *Qualitative Inquiry and Research Design, Choosing Among Five Approaches*. Thousand Oaks, California: Sage Publications, Inc.

- Cukr, P.L., Jones, S.L., Wilberger, M.E, Smith, R. & Stopper, C. (2004). The psychiatric clinical nurse specialist/nurse practitioner: an example of a combined role. *Archives of Psychiatric Nursing*. Vol. 12, No. 6, p. 232-236
- Daly, W.M. & Carnwell, R. (2003). Nursing roles and level of practice: a framework for differentiating between elementary, specialist and advancing nursing practice. *Journal of Clinical Nursing*. Vol.12, p. 158-167.
- Delaney, R. (2005). Reflection: personal characteristics of potential nurse practitioner. *Journal of Clinical Nursing*. Vol.1, p. 13-16.
- Dal Poz, M.R., Quain, E.E., O'Neil, M., McCaffery, J., Elzinga, G. & Martineau, T. (2006). Addressing the health workforce crisis: towards a common approach. *Human Resources for Health*. Vol.4 No. 21, p 67-72.
- De Dreu, C. K. W. (2007). Cooperative outcome interdependence, task reflexivity, and team effectiveness: A motivated information processing perspective. *Journal of Applied Psychology*. Vol. 92, p. 628-638.
- De Geest, S., Moons, P., Callens, B., Gut, C., Lindpainter, L. & Martineau, T. (2006). Introducing advanced practice nurses/nurse practitioners in health care systems: a framework for reflection and analysis. *Swiss Medical Weekly*. Vol. 138, p. 621-628.
- DiCicco-Bloom, B. & Crabtree, B.F. (2006). Making sense of qualitative research: the qualitative research interview. *Medical Education*. Vol. 40, p.314-321.
- Department of Health. (2007). Recognitions of nursing specialty OSD document, Annexure A.
- DoH (2004a) Substantial allowances ready to roll for health professionals. Accessed 28 November 2007, <http://www.doh.gov.za>
- DoH (2007c). Occupation specific dispensation (OSD) in the public service. 12 June. Accessed 7 January 2008, <http://www.doh.gov.za>
- DoH (2007d). Signing of a collective agreement on occupational specific dispensation for nurses, Centurion, 14 September. Accessed 18 September 2007, <http://www.info.gov.za/speeches/2007/07091810151001.htm>
- Duffield C. & O'Brien-Pallas L. (2003). The causes and consequences of nursing shortages: a helicopter view of the research. *Australian Health Review*. Vol.26, p. 186–193.
- Duffy MM. (2001). Arranging clinical affiliations. *Journal for Nurses in Staff development*. Vol.17, p. 41–43.

- Dunn, K. & Nicklin, W. (1995). The status of advanced nurses in Canadian teaching hospitals. *Canadian Journal of Administration*. p. 111-113.
- Duran, R., Aladya, N., Vantansaver, U., Kucukugurlogly, Y., Sut, N. & Anucas, B. (2008). Proficiency and knowledge gained and retained by paediatric residents after neonatal resuscitation course. *Paediatric International*. Vol. 50, p. 644-647.
- Elsom, S., Happell, B. & Manias, E. (2009). The clinical nurse specialist and nurse practitioner roles: room for both or take your pick, *Australian Journal of Advanced Nursing*. Vol. 22, No.2, p.56-59.
- Evans K. (2001). Rotational programmes for newly qualified nurses. *Nursing Times*. Vol. 97, p.42-44.
- Flisher, A.J., Lund, C., Funk, M., Bhana, M. & Doku, V. (2007). Mental health policy development in four African countries. *Journal of Health Psychology*. Vol. 12, p. 505-516.
- Freeth, D., Hammick, M., Reeves, S., Koppel, I., & Barr, H. (2005). Effective interprofessional education. Development, delivery & evaluation. Oxford: Blackwell Publishing Ltd.
- Fouché, NA (2007). What does the Occupation – Specific Dispensation (OSD) in the public service mean for nursing? *SA journal of Critical Care (SAJCC)* Vol.23, No, 2, p. 53-54.
- Furlong, E. & Smith, R. (2005). Advanced nursing practice: policy, education and role development. *Journal of Clinical Nursing*. Vol. 14, p. 1059-1066.
- Gardner, G., Chang, A., & Duffield, C. (2006). Making nursing work: Breaking through the role of advanced practice nursing. *Journal of Advanced Nursing*. Vol. 57, No. 4, p. 382-391.
- Gardner, A. & Gardner, G. (2005). A trial of nurse scope of practice. *Journal of Advanced Nursing*. Vol. 49, p. 135-145.
- Gardner, G., Gardner, A. and Proctor M. 2007. Nurse Practitioner education: a curriculum structure from Australian research. *Journal of Advanced Nursing*. Vol. 9, p. 133-141.
- Gardner A, Hase S, Gardner G, Dunn SV & Carryer J (2008) From competence to capability: a study of nurse practitioners in clinical practice. *Journal of Clinical Nursing*. Vol. 17, p. 250-258.

- George, G.L. & Rhodes, B. (2012). Is there really a pot of gold at the end of the Rainbow? Has the Occupational Specific Dispensation, as a mechanism to attract and retain health workers in South Africa, leveled the playing field? *BMC Public Health*, p.12-613.
- Geyer, N. (2001). Enabling legislation in diagnosis and prescribing of medicine by nurse/health practitioner. *Curationis*. Vol.24, No. 4, p. 17-24.
- Gill, K., & Hough, S. (2007) Nurse practitioners are a benefit, not a threat. *Journal of Clinical Nursing*. Vol. 21, p. 223–243
- Gillis, A. & Johnson, W. (2002). Research for nurses. Methods and interpretation, Philadelphia: Blackwell.
- Girot, E.A. (2000). Assessment of competency in clinical practice: a phenomenal approach. *Journal of Advanced Nursing*. Vol. 32, No. 1, p. 114-119.
- Goodin H.J. (2003). The nursing shortage in the United States of America: an integrative review of the literature. *Journal of Advanced Nursing*. Vol.43, p. 335–343.
- Goldstein, I. (2007). Supplementary prescribing: relationship between the nurse and the psychiatrist. *Journal of Clinical Nursing*. Vol. 33, p. 439–441.
- Guest, D., Peccei, R., Redfern, S., Young, C., Wilson-Barrett, j. (2002). The role of a nurse consultant in expanded critical care. *Journal of Research Nursing*. Vol. 25, p.23-35.
- Hall, P. (2005). Interpersonal teamwork: professional cultures as barriers. *Journal of Interprofessional Care*. Vol. 19, No. 1, p. 188-196.
- Hamric, A. (2000). Advanced Nursing Practice. An Integrative Approach, 2nd edition. WB Saunders, London.
- Hanson, C. & Hamric A. (2003). The nursing practice environment, staff retention, and quality of care. *Research in Nursing and Health*. Vol. 19, p. 331–343.
- Hanrahan, N.P. & Hartley D. (2008). Employment of advance practice psychiatric nurses to stem rural mental health workforce shortages. *Psychiatric Services*. Vol. 59, NO.1, p.109-111.
- Henneman, E.A., Lee, J.L. & Cohen, J.I. (1995). Collaboration: a concept analysis. Vol. 21, p. 103–109.
- Herrman, H., Saxena, S., Moodie, R., WHO. (2005). Promoting mental health: Concepts, emerging evidence, practice. *A Report from the World health Organisation, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and The University of Melbourne*. Geneva. WHO.

- Hartley, H. (2002). The system of alignments challenging physician professional dominance. An elaborated theory of counteracting powers. *Sociology of Health and Illness*. Vol.24, No.2, p. 178-207.
- Hau, W.W. (2004). Caring holistically within new managerialism. *Nursing Inquiry*, Vol. 11, No. 1, p. 2-3.
- Hogan, B., & Shattell, M. (2007). Psychiatric clinical nurse specialists, nurse practitioners, or the new practice doctorate. Meeting patients' needs. *Issues in Mental Health Nursing*, Vol. 28, No. 8, p. 927-930.
- Holloway, I. & Wheeler, S. (1996). *Qualitative research for nurses*. London: Blackwell.
- Horrock, S., Anderson, E. & Salisbury, C. (2002). Systematic review of whether nurse practitioners working in primary care can provide equivalent care to doctors. *British Medical Journal*. Vol. 324, p. 819-823.
- Jensen K. & Aamodt P.O. (2002). Moral motivation and the battle for students: the case of studies in nursing and social work in Norway. *Higher Education*. Vol.44, p. 361–378
- Jones, J.S. & Minarik, P.A. (2012). The plight of the psychiatric clinical nurse specialist. The dismantling of the advanced practice nursing archetype. *Clinical Nurse Specialist*. p. 121-127.
- Jones, J.S. (2012). Credentialing and psychiatric clinical nurse specialist practice. *Journal of Advance Nursing*. Vol. 24, No. 1, p. 38-40.
- Joyce P (2002) Nursing management – an Irish perspective: challenges in the third millennium. *The All Ireland Journal of Nursing and Midwifery*. Vol. 2, p. 40–41.
- Ketefian, S., Redman, R.W., Hanucharunkul, S., Masterson, A., Neves, E.P. (2001). The development of advanced practice roles: implications in the International nursing community. *International Nursing Review*. Vol.48, p.152-163.
- Kinnersley, P., Anderson, E., Parry, K., Clement, J., Archard, L., Turton, P. Stanhope, A., Fraser, A. & Rogers, C. (2000). Randomized controlled trials of nurse practitioner versus general practitioner care for patients requesting same day consultations in primary care. *British Medical Journal*. Vol. 320, p. 1043-1048.
- Khoza, L.B. & Ehlers V.J. (2008). The competencies of newly qualified psychiatric nurses. *Health S.A. Gesundheit*. Vol. 5, No. 3, p. 50-59.

- Khalil, D. (2006). Advanced practice nurses in South Africa. Program and abstracts of the 4th ICN International Nurse Practitioner Advanced Practice Nursing Network Conference, June 28–30, Sandton, South Africa.
- Kring, D.L. (2008). Clinical nursing practice domains and evidence-based practice competencies. *Journal of Clinical Nurse Specialist*. Vol. 22, No. 4, p. 179-183.
- Kvarnstrom, S., & Cedersund, E. (2006). Discursive patterns in multiprofessional healthcare teams. *Journal of Advanced Nursing*. Vol. 53, p. 244 – 252.
- Kvarnstrom, S. (2008). Difficulties in collaboration: A critical incident study of interprofessional healthcare teamwork. *Journal of Interprofessional care*. Vol. 22, p. 191-203.
- Leonard, M., Graham, S., & Bonacum, D. (2004). The human factor: The critical importance of effective teamwork and communication in providing safe care. *Quality and Safety in Healthcare*. Vol.13, p. 85–90.
- Leiter, M. P., & Laschinger, H. K. S. (2006). Relationships of work and practice environment to professional burnout. *Nursing Research*. Vol.55, p.137–146.
- Lehman, F., Dieleman, A. & Martineau, U. (2008). Staffing remote rural areas in middle and low income countries: a literature review of attraction and retention. *BMC Health Services Research*. Vol. 8, No. 19, p. 1-10.
- Lindeke, L. L. & Siekert, A. M. (2005). Nurse-physician workplace collaboration. *Online Journal of Issues in Nursing*. Vol.10, p. 1–15.
- Lloyd Jones, M. (2004). Role development and effective practice in specialist and advanced practice roles in acute hospital setting: system review and meta-synthesis. *Journal of Advanced Nursing*, Vol.49, No. 2, p.191-209.
- Lyon, B.L. (2004). The CNS regulatory quagmire-we need clarity about advanced nursing practice. *Clinical Nurse Specialist*. Vol. 18, p. 9-13.
- Mahoney, J. (2001). Leadership skills for the 20st century. *Journal of Nursing Management*. Vol.9, p. 269-271.
- Mantzoukas, S. & Watkinson, S. (2007). Review of advanced nursing practice: the international literature and developing the generic features. *Journal of Clinical Nursing*. Vol. 16, p. 28-37.

- Marsden, J. & Street C. (2004). Nurse practitioner and development. *Journal of Advanced nursing*. Vol. 43, p. 595-605.
- Martin, D., O'Brien, J., Hetworth, J., & Meyer, N. (2005). The collaborative healthcare team: Tensive issues warranting on-going consideration. *Journal of the American Academy of Nurse Practitioners*. Vol.17, p. 325–330.
- Mayo, A.M., Omery, A., Agocs-Scott, L.M., Khaghani, F., Moti, N., Redeemer, J., Voorhees, M., Gravell, C., &Cuenca, E. (2010). Clinical Nurse Specialist Practice Patterns. *Clinical Nurse Specialist*. p.60-68.
- McDonald, A., Bennett, L., Dwyer, R.D., Martin, C. (2006). Nurse practitioners: an evaluation of extended role of nurses. *Australian Journal of advanced nursing*. Vol. 18, No. 3, p. 20-28.
- McCluskey, A. & Lovarini, M. (2005). Providing evidence based practice evidence improved knowledge but did not change behaviour: a before and after study. *BMC Medical Education*. Vol. 5, No. 40, p. 1-12.
- McCreddie M. (2001). The role of the clinical nurse specialist. *Nursing Standard*. Vol. 16, p. 33–38.
- McGee P. & Castledine G. (2003) A Survey of specialist and advanced nursing practice in the UK. *British Journal of Nursing*. Vol. 8, p. 1074–1078.
- McGrath J. (2004). *Social Psychology: A Brief Introduction*. Holt, Rinehart, and Winston, New York
- Meads, G., & Ashcroft, J. (2005). Collaboration: The case for interprofessional collaboration in health and social care. *Journal of Clinical Nursing*. 15 – 35.
- Mee C.L. & Robinson E. (2003). What's different about this nursing shortage? *Nursing*. Vol. 33, p. 51–55.
- Miles, K., Seitio, O. & McGilvray, M. (2006). New prescribing in low-setting: professional considerations. *International Council of Nurses*. Vol. 53, p. 290-296
- Mitchell-DiCenso A., Pinelli J. & Southwell D. (1996) Introduction and evaluation of an advanced nursing practice role in neonatal intensive care. In *Outcomes of Effective Management Practice*. *Journal of Advanced Nursing*. Vol. 25, p. 257–264.
- Morse, J.M. & Field, P.A. (1995). *Qualitative research methods for health professionals*. 2nd edition. Thousand Oaks, CA: Sage.

- Mouton, I. (2001). *How to succeed in your Master's and Doctoral Studies: A South African guide and resource book*. Pretoria: Van Schaik Publishers.
- Mundinger, M.O., Kane, R.L., Lenz, E.R., Totten, A.M., Tsai, W., Cleary, P.D., Friedewald, W.T., Siu, A.L., & Shelanki, M.L. (2000). Primary health care outcomes in patients treated by nurse practitioners to physicians. *Journal of American Medical Association*. Vol. 283No.1, p. 59-68.
- Nursing and Midwifery Council (2006). Advanced nurse practitioner accredited. *National Council for the Professional development of nursing and midwifery Quarterly Review*. Vol. 23, p. 20.
- Nursing Act (Act 33 of 2005). Republic of South Africa. Available at 078.<http://www.info.gov.za/view/DownloadFileAction?id=67887> (Accessed 19 March 2012).
- O'Brien, J.L., Martin, D.R., Heyworth, J.A. & Meyer, N.R. (2009). A phenomenological perspective on advanced practice nurse-physician collaboration within an interdisciplinary health care team. *Journal of the American Academy of Nurse Practice*. p. 444-453.
- O'Connor, L. & Furlong, E. (2002). From the United States to the southern Ireland: translating the role of the advance practice nurse. *Journal of Advance Nursing*. Vol.29, p. 1037-1038
- Olson, R.K., Nelson, M., Stuart, C., Young, L., Kleinsasser, A., Schroedermeier, R., Newstrom, P. (2001). Nursing Student Residency Program: a model for a seamless transition from nursing student to RN. *Journal of Nursing Administration*; Vol.31, p.40-48.
- Offredy, M. & Townsend B. (2000). Advanced nursing practice: the case of nurse practitioners in three Australian states. *Journal of Advanced Nursing*. Vol. 31, 274-281.
- Orfanidis, D. (2007). Perioperative nurse-physician collaboration and nurse satisfaction with decision-making. *AORN Proceedings*. Vol85, p. 1155-1156.
- O'Reilly, S. (2000). An evaluation of clinical nurse specialist: implications for education and the organisation of care. *Journal of Advanced Nursing*. Vol. 9, p. 11-16.
- Oxford Advanced Learner's Dictionary (2012). (10th Ed.). New York: Oxford University Press.
- Paudel, R.B. (2005). Clinical research in Finance. *Journal of Nepali Business Studies*. Vol. 11, p. 25-29

- Pearson, A. & Peels, S. (2002). Clinical nurse specialist. *International Journal of nursing Practice*. Vol. 8, p. 11-14.
- Petersen, I., Bhana, A., Campbell-Hall, V., Mjadu, S., Lund, C., Kleintjies, S., Hoesegood, V., Flisher, A.J. & The Mental Health and Poverty Research programme Consortium (2009). Planning for district mental health in South Africa: a situational analysis of a rural district site. *Health Policy and Planning*. Vol. 24, p. 140-150.
- Phillips, S.J. (2006). 18th annual legislative update: A comprehensive look at the legislative issues affecting advanced nursing practice. *Journal of Nursing*. Vol. 8, No. 2, p. 60–64.
- Phillips, R., Green, L., Fryer, G., & Dovey, S. (2001). Trumping professional roles: Collaboration of nurse practitioners and physicians for a better U.S. health care system. *American Family Physician*. Vol. 64, p. 1325.
- Pilane, C.N., Ncube, R., & Seitio, O.S. (2007). Ensuring quality in affiliated health training institutions: Advanced diploma programs in Botswana. *ICN-Advanced Practice Nursing Network Bulletin*. No. 7. <http://www.icn-apnetwork.org>.
- Polit, D.F. & Beck, C.T. (2012). Nursing research: Generating and assessing evidence for nursing and practice. 9th edition. New York: Williams and Wilkins company.
- Por, J. (2008). A critical engagement with the concept of advancing in nursing practice. *Journal of Nursing Management*. Vol. 16, p. 84-90.
- Powers, S. & Knapp, W. (2000). Qualitative research methodology. *Journal of Qualitative Research*. Vol. 5, p. 26-32.
- Rapp, M.P. (2003). Opportunities for advance nurses in the nursing. *Facility of American Medical Directors Association*. Vol. 14, p. 337-343.
- Radford M. (2003). Redefining perioperative advance practice. The nurse specialist in anaesthesia and emergency surgery. Defining the problem and providing a solution. *British Journal of Perioperative Nursing*. Vol. 13, p. 468–471.
- Read, S.M. (2001). Exploring new roles in practice. *Journal of Advanced Nursing*. Vol. 21, p. 35-42.
- Richardson, A., Douglas, A., Stuttler, R. & Hagland, R. (2003). Critical care staff rotation outcome survey and pilot study. *Journal of Advanced Nursing*. Vol. 8, No. 2, p. 85-89.
- Rosen, R. and Mountford, L., 2002. Developing and supporting extended nursing roles: the challenges of NHS Walk-in centres. *Journal of Advanced Nursing*. 39 (3), 241–248.

- Rosenthal, R.H., Levine, R.E., Carlson, D.L., Clegg, K.A. & Crosby, R.D. (2005). The shrinking clerkship: Characteristics and length of clerkship in psychiatry undergraduate education. *Academic Psychiatry*. Vol. 29, No. 1, p. 47-51.
- Ross, F., Rink, E. & Furne, A. (2000). Integration or pragmatic coalition? An evaluation of nursing teams in primary care. *Journal of Interprofessional Care*. Vol. 14, No. 3, p. 259–267.
- Ruel, J. & Motyka C. (2009). Advanced practice nursing: A principle-based concept analysis. *Journal of the American Academy of Nurse Practitioners*. Vol. 21, p. 384-392.
- Salhani, D. & Coulter N. (2009). The politics of interprofessional working autonomy in nursing. *Social Science and Medicine*. Vol. 68, p. 1221-1228
- Schober, M. & Affara, F. (2006). *Advanced nursing practice*. Oxford, UK: Blackwell.
- Seitio, O. (2006). Advanced practice education in Botswana. Program and abstracts of the 4th ICN International Nurse Practitioner Advanced Practice Nursing Network Conference, Sandton, South Africa.
- Saraceno, B., Ommeren, M. Batniji, R. Cohen, Gureje, O., Mahoney, J. Sridhar, D. & Underhill, C. (2007). Barriers to improvement of mental health services in low-income and middle-income countries. *Global Mental Health*. Vol. 370, p. 1163-1172.
- Shanton, A.K. (2004). Strategies for ensuring trustworthiness in qualitative research. *Project Education for Information*. Vol. 22, No. 2, p. 63-75.
- Silverman, D. (2001). *Doing Qualitative Research. A practical handbook*. Sage publications: London.
- Simoens, S., Villeneuve, M. & Hurst, J. (2005). *Tackling nurse shortage in OECD Countries*. Organization for Economic Co-operation and Development (OECD) Health Working Papers no.19. Directorate for Employment, Labour and Social Affairs.
- Sirota, T. (2007). Nurse-physician relationships: Improving or not? *Nursing*. Vol.37, p.52–55.
- Skreen, S., Kleintjies, S., Lund, C., Petersen, I., Bhana, A., Flisher, A.J. (2010). Mental health is everybody's business: Roles for an intersectoral approach in South Africa. *International Review of Psychiatry*. Vol. 22, No. 2, p. 611-623.
- Sheer, B. & Wong, F.K.Y. (2008). The development of advanced nursing practice globally. *Journal of Nursing Scholarship*. Vol. 40, No.3, p.204-211.

- Smith, J.A., Flowers, P. & Larkin, M. (2009). Interpretative phenomenological analysis of theory, method and research. Los Angeles: Sage publications.
- Smith, O. (2003). Advanced nursing practice in emergency care. *The All Ireland Journal of Nursing and Midwifery*. Vol. 2, p. 40-44.
- South African Nursing Council regulation R212, as amended January 1997.
- South African Nursing Council (2012). Advanced Practice Nursing Draft Position Paper
- Spitzer W.O. (1978). Evidence that justifies the introduction of new health care professionals: PEPPA framework. *The Professions and Public Policy*. p. 211–236.
- Sullivan, E.J. & Decker P.J. (2000). *Effective leadership and Management* (5th Ed). Prentice Hall: New York.
- Terre Blanche, M. & Durrheim, K. (2001). Research in practice. Applied methods for social sciences. Cape Town: University Press.
- Towns W, Wink D. (2002). Two views on clinical rotations: different students each time or always the same? *Nurse Educator*. Vol. 27, p.65–67.
- USA Nurse Training Act (1964). Kate Hurd-Mead lecture. Nursing the Great Society: the impact of the Nurse Training Act of 1964.
- Venning, P., Durie, A., Roland, M., Roberts, C. & Leese, B. (2000). Randomised controlled trial comparing cost effectiveness of general practitioners and nurse practitioners in primary health care. *British Medical Journal*. Vol. 320, No.7241, p. 1048-1053.
- Walker, J. (2008). The clinical nurse specialist. *Journal of Orthopaedic Nursing*. Vol. 12, p. 5-12.
- Weaver, K. & Olson, K. (2005). Understanding paradigm uses for nursing research integration. *Journal of Advanced Nursing*. VOL. 19, P. 733-737.
- Wheeler, H.H., Cross, V., Anthony, D. (2000). Limitations, frustrations and opportunities: a follow up study of nursing graduates from the University of Birmingham, England. *Journal of Advanced Nursing*; Vol.32, p.842–85.
- Williams, K.S., Assassa, R., Smith, N.K., Jagger, C., Perry, S., Shaw, C., et al. (2000). Development, implementation and evaluation of a new nurse-led continence service: A pilot study. *Journal of Clinical Nursing*, Vol. 9, p. 566–573.
- Willing, C. (2002). Introducing qualitative research in psychology. Adventures in theory and method. Philadelphia: Open University Press.

- Wilson-Barett, J., Barriball, K.L., Reynolds, H., Jowett, S. & Ryrie, I. (2002). Recognizing advance nursing practice: evidence from two observational studies. *International Journal of nursing Studies*. Vol. 37, p. 389-400.
- Wong, F.K.Y., & Chung, L. (2006). Establishing a model for nurse-led clinic: Structure, process and outcome. *Journal of Advanced Nursing*. Vol. 53, No. 3, p. 358–369.
- World Health Organization Report (2001). A call to action by the world health ministers. Geneva, World Health Organization.
- World Health Organization Report (2004). Mental Health: new understanding, new hope. *The World Health Report*. Geneva, World Health Organization.
- World Health Organization (WHO) (2006b). *Migration of Health workers*. <http://www.who.int> (Accessed 07 November 2007).
- Zwarenstein, M., & Bryant, W. (2007). Interventions to promote collaboration between nurses and doctors. *Cochrane Database Systematic Reviews*. Vol4, p. 1–10.

**TRANSCRIPTS
ANNEXURE: A**

Page 1 of 2

LETTER REQUESTING INSTITUTIONAL SUPPORT

35 HAYNES ROAD

BISLEY

PIETERMARITZBURG

3201

20 October 2011

ATTENTION: DR KING

KWAZULU-NATAL DEPT OF HEALTH

TOWNHILL HOSPITAL

P.O. BOX 400

PIETERMARITZBURG

3200

RE: REQUEST FOR PERMISSION TO CONDUCT A STUDY

**TITLE: EXPLORATION OF THE STAKEHOLDER'S PERCEPTION OF THE
ADVANCED PSYCHIATRIC NURSE PRACTITIONERS ROLE IN THE
PROVISION OF CARE IN A PSYCHIATRIC HOSPITAL AT
UMGUNGUNDLOVU DISTRICT**

RESEACHER: R.T. ZONDI (UKZN Student No: 209521222)

SUPERVISOR: A. Smith

Dear Dr. King

I Ronah Tholakele Zondi (Student Number: 209521222) would like to conduct a research study about the advanced practice psychiatric nurse's role in Townhill hospital. Enclosed please receive the research proposal. The ethical clearance letter is

from the UKZN ethical committee is enclosed. The purpose of the study is to explore and describe stakeholder's perceptions of the advanced psychiatric nurse practitioner's role in the provision of mental health / psychiatric health care.

The study might benefit the institution in improving the level of efficiency in rendering nursing care to the mental health care users. An audio tape will be used to collect data during the interviews and each session will about 45 minutes. The study does not have any risk or discomfort and is conducted as a requirement for the Masters Degree purpose.

All material used for the collection of data will be destroyed by fire after five years. The results of the study will be communicated to you and copies will be given to UKZN, your hospital and Department of health.

If you have any questions about the study please feel free to contact me or my supervisor, Ms A. Smith, at the following numbers.

Yours Sincerely



Mrs. R. T. Zondi Work: 033 3927577

Cell No: 0835145298

Ms A Smith Work: 031 2603578

Supervisor: Ms A Smith

UKZN School of Nursing

Academic coordinator decentralized mental health programs (Acting)

5th Floor Desmond Clarence Building

Email: smitha1@ukzn.ac.za

ANNEXURE: B



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

TOWNHILL HOSPITAL
P O Box 400, Pietermaritzburg, 3200
400 Hyslop Road, Pietermaritzburg, 3201
Tel.: 033 3415843, Fax.: 033 3942105
Email.: nozipho.mchunu@kznhealth.gov.za
www.kznhealth.gov.za

13 February 2012

School of Nursing
Pietermaritzburg

Attention: Mrs R Zondi

**Re: AN EXPLORATION OF STAKEHOLDERS PERCEPTIONS OF THE ADVANCED
PSYCHIATRIC NURSE PRACTITIONERS ROLE IN THE PROVISION OF HEALTH CARE IN A
PSYCHIATRIC HOSPITAL AT UMGUNGUNDLOVU DISTRICT**

Approval has been granted for the above-named research to be conducted at Townhill Hospital, Pietermaritzburg by the Townhill Hospital Research and Ethics Committee at a meeting conducted on Monday 13 February 2012 and Chaired by Dr H V King.

Please note that Head Office needs to be notified of this research study that is going to be conducted at Townhill Hospital.

Yours sincerely,



uMnyango Wazempilo . Departament van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

ANNEXURE: C

A LETTER TO THE PROSPECTIVE PARTICIPANTS IN A RESEARCH STUDY TO OBTAIN INFORMED CONSENT

TITLE: EXPLORATION OF THE STAKEHOLDERS PERCEPTION OF THE ADVANCED PSYCHIATRIC NURSE PRACTITIONER'S ROLE IN THE PROVISION OF CARE IN A PSYCHIATRIC HOSPITAL AT UMGUNGUNDLOVU DISTRICT

RESEACHER: MS R.T. ZONDI

Dear Participant

I Ronah Tholakele Zondi (Student Number: 209521222) will be conducting a research study as a requirement for the Masters degree on mental health about advanced practice psychiatric nurses role in a psychiatric hospital. I hereby invite your participation and feedback in the research study. The purpose of the study is to explore and describe stakeholder's perceptions of the advanced practice psychiatric nurse's role in the provision of mental health / psychiatric health care.

The study might benefit you as an advanced practice nurse in improving the level of efficiency in rendering nursing care to the mental health care users. The study does not have any risk or discomfort and is conducted as a requirement for the Masters Degree purpose. Your anonymity is guaranteed which means that your name will not appear in the documents.

You will receive no remuneration; however your participation will be of great value for provision of quality nursing care. An audio tape will be used to collect data and the interviews will last for approximately 45 minutes. Your participation to this study is totally voluntary and you can withdraw at any time without any penalty. You may cancel your participation at any time even after you have signed the consent. Your participation in this study is totally voluntary and you can withdraw without any penalty.

Please note that once interviews have been transcribed and coded it is not possible to withdraw the data as the researcher will be unable to identify your response from those of others. All material used for the collection of data will be destroyed by fire after five years. The results of the study will be communicated to you and copies will be given to UKZN, your hospital and

ANNEXURE: D

LETTER REQUESTING DEPARTMENT OF HEALTH SUPPORT

35 HAYNES ROAD

BISLEY

PIETERMARITZBURG

3201

28 February 2012

ATTENTION: MR. XABA

KWAZULU-NATAL DEPT OF HEALTH

PROVINCIAL HEALTH RESEARCH COMMITTEE

PIETERMARITZBURG

3200

RE: REQUEST FOR PERMISSION TO CONDUCT A STUDY

**TITLE: EXPLORATION OF THE STAKEHOLDERS PERCEPTION OF THE
ADVANCED PSYCHIATRIC NURSE PRACTITIONERS ROLE IN THE
PROVISION OF CARE IN A PSYCHIATRIC HOSPITAL AT
UMGUNGUNDLOVU DISTRICT**

RESEARCHER: R.T. ZONDI (UKZN Student No: 209521222)

SUPERVISOR: A. Smith

Dear Mr. Xaba

I Ronah Tholakele Zondi (Student Number: 209521222) would like to conduct a research study about the advanced practice psychiatric nurse's role in Townhill hospital. The purpose of the study is to explore and describe stakeholders perceptions of the advanced psychiatric nurse practitioner's role in the provision of mental health / psychiatric health care.

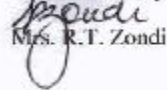
The study might benefit the institution in improving the level of efficiency in rendering nursing care to the mental health care users. An audio tape will be used to collect data during the interviews and each session will be about 45 minutes. The study does not have any risk or discomfort and is conducted as a requirement for the Master's Degree purpose.

All material used for the collection of data will be destroyed by fire after five years. The results of the study will be communicated to you and copies will be given to UKZN, the hospital and Department of health.

Enclosed please find the ethical clearance forms from the UKZN and Townhill hospital

If you have any questions about the study please feel free to contact me or my supervisor, Ms A. Smith, at the following numbers.

Yours Sincerely


Mrs. R.T. Zondi

Work: 033 3927577

Cell No: 0835145298

Ms A Smith

Work: 031 2603578

Email: smitha1@ukzn.ac.za

Supervisor: Ms A Smith

UKZN School of Nursing

Academic coordinator decentralized mental health programs

(Acting)

5th Floor Desmond Clarence Building

email: smitha1@ukzn.ac.za



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

Health Research & Knowledge Management
10 – 103 Natalia Building, 330 Langalibalele Street
Private Bag x9051
Pietermaritzburg, 3200
Tel.: 033 – 395 2895
Fax.: 033 – 394 3782
Email: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

Reference : HRKM 150/11
Enquiries : Mr X. Xaba
Telephone : 033 – 395 2805

Dear Ms RT Zondi

Subject: Approval of a Research Proposal

1. The research proposal titled '**Exploration of the stakeholders' perception of the advanced psychiatric nurse practitioners role in the provision of care in a psychiatric hospital at UMgungundlovu District**' was reviewed by the KwaZulu-Natal Department of Health.

The proposal is hereby approved for research to be undertaken at Town Hill Hospital until October 2012.

2. You are requested to take note of the following:
 - a. Make the necessary arrangement with the identified facility before commencing with your research project.
 - b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.
3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Mr X. Xaba.

Yours Sincerely


Dr E. Lutge
Chairperson: Provincial Health Research Committee
KZN Department of Health
Date: 02/02/2011

uMnyango Wezempilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

ANNEXURE: F



Research Office (Govan Mbeki Centre)
Private Bag x54001
DURBAN, 4000
Tel No: +27 31 260 3587
Fax No: +27 31 260 4609
Ximhap@ukzn.ac.za

18 October 2011

Mrs R T Zondi (209521222)
School of Nursing

Dear Mrs Zondi

PROTOCOL REFERENCE NUMBER: HSS/1031/011M

PROJECT TITLE: An exploration of stakeholders perceptions of the advanced psychiatric nurse practitioner's role in the provision of health care in a psychiatric hospital at Umgungundlovu district

EXPEDITED APPROVAL

I wish to inform you that your application has been granted Full Approval through an expedited review process:

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

Professor Steven Collings (Chair)
Humanities & Social Sciences Research Ethics Committee

cc Supervisor – Ms A A Smtih
cc Mr S Reddy



Founding Campuses: ■ Edgewood ■ Howard College ■ Medical School ■ Pietermaritzburg ■ Westville

ANNEXURE: G

CONSENT FORM

I..... (Please insert surname and initials)
understand what is in the information sheet and I agree to participate in the research study
conducted by Mrs. R.T. Zondi.

I fully understand the conditions and time commitment involved in my participation.

I understand that my participation is voluntary and that I may withdraw my consent without
penalty.

I freely give consent to take part on this research study

Participants signature.....

Researchers Name: Mrs. R T Zondi

Researches' signature.....

ANNEXURE: H

INTERVIEW SCHEDULE/GUIDE

SECTION A (Demographic data)

This demographic section will be completed by the researcher:

1. Age (years):
2. Gender: MALE FEMALE
3. Race:
4. NO of experience as a psychiatric nurse:
5. Job Title:

ANNEXURE: I

SECTION B

Central questions

1. How did it happen that you were allocated to your ward?
2. What type of service is offered in your ward?
3. What are you expected to do on a day to day basis?
4. What are psychotherapeutic interventions that are conducted in your ward?
5. What level of knowledge and ability is required to perform your duties?
6. Are you in charge of any project in your ward?
7. Are there policies in your ward which guide your practice?
8. What are the barriers to the fulfillment of your role?
9. Are you involved in decision making for patient care?

ANNEXURE J

EMERGENT THEMES:

NO.	THEMES	MEANING
1.	Collaboration	Collaborations emerged as an essential component in the development of the role of the advance practice nurse. According to the participants the relationship between the nurse and the doctor plays an important role in the delivery of care
2.	Model of care	The model of care which is still prevalent in the hospital is the biomedical model. The participants are blaming the doctors for the status quo
3.	Information/knowledge	There is a an outcry from the participants for update as advanced psychiatric nursing has evolved over years
4.	Scope of practice	The lack of clear guidelines was a major concern for the participants. That contributed to role ambiguity and confusion
5.	Lack of resources	Lack of resources is cited by participants as a major barrier in commencing projects
6.	Rotation of staff	Rotation of staff is seen by participants as a stumbling block for continuity of care
7.	Shortage of staff	The shortage for staff especially those with advance psychiatry is a concern. The participants find themselves having to do more with less and that is taxing to both the MHCUs and nurses.
8.	Occupational Specific Dispensation	The participants felt that the OSD was causing conflict in the delivery of care thus promoting discontent among participants
9.	Organizational support	Lack of support from the management is a hindrance in the performance of duty as expected

ANNEXURE K

1. INTERVIEWS

2. TRANSCRIPTIONS OF INTERVIEWS HELD WITH PARTICIPANTS

3. FOCUS GROUP DISCUSSION 1

4. **Interviewer:** Good morning colleagues

5. **Participants:** Morning

6. **Interviewer:** How did it happen that you were allocated to your ward?

7. **Participant:** I was allocated to this unit because I've got advanced psychiatry

8. **Participant:** I was allocated by the matrons office

9. **Interviewer:** What type of service is offered in your ward?

10. **Participant:** As I said this is a child assessment unit we do a lot of rehabilitation, group

11. therapies and we concentrate more on the social aspect of the child. Most of the time

12. we deal with the disability grant, a lot of problems and sometimes there will be rape

13. cases that we will need to refer to the psychologist that type of things. We try and use

14. all the avenues when the child when we are dealing the child and we cater for whatever

15. the child needs.

16. **Participant:** A lot of group, we also even though we are not trained in teaching, we

17. run sessions with the children. When they come in we asked the schools to send in their

18. set books and we do a lot of schoolwork as such with them. If they are doing L.O. we

19. would do that type of subject with them. With their maths aah we will try to make sure

20. that their homework is done. We try and ask the teachers to send their homework with

21. them if is possible and if it's not possible we ask the parents to bring in their set books.

22. We asked the teachers to send homework for them if it's possible. Sometimes we

23. asked the parents to actually get the homework or send the child with their homework.

24. We also do a lot of family therapy. The family comes in and actually try and ascertain

25. what the problem is with the children, try to get down to the root of the problem.

26. **Participant:** A lot of therapies and we try and implement of CBT (Cognitive behaviour therapy) and in

27. some children it's not feasible and we also at times if possible do narrative therapy with

28. the children. At times we try and get the syllabus from the teacher if we can contact the

29. teacher but we try and get the syllabus from the teachers or most often the children

30. coming with their books so we look at the books and see what they are doing and every

31. in morning from nine to twelve is the school routine and after that we concentrate on

32. the group work.

33. **Interviewer:** What are you expected to do on a day to day basis?

34. **Participant:** On a day to day basis we actually when we come on duty we take over

35. from night staff, we make sure that the children have a bath and we see to their basic

36. needs. We see that they have their breakfast and after they have their breakfast as I said

37. from nine o'clock to twelve o'clock they have their schoolwork and after school work

38. it's their lunch. The children are actually encouraged to be active like... they dish out

39. for themselves and they also... they do their schoolwork then their lunch.

40. **Participant:** When they have their lunch they go and they have a rest period from half

41. past twelve to half past two thereafter we do various other groups with the children

42. including whatever is set for the day. For example today we focus on TB, we did TB

43. health education. We also focus on their age level of whatever age level they are then

44. we do for example menstruation. Three of our children here are from 11-12 years old
45. and they have not yet had their menses. So we also tend to focus on that type of thing
46. to inform them. So we try and concentrate on that type of thing.

47. **Participant:** We also try and do group on self-esteem because most of the children in
48. this department lack self-esteem. We also do whatever is necessary we don't have a
49. formal programme as the unit is fairly new.

50. **Interviewer:** What are psychotherapeutic interventions that are conducted in your
51. Ward?

52. **Participant:** What exactly do you mean?

53. **Interviewer:** I mean therapeutic interventions like CBT, psychotherapy

54. **Participant:** We do a lot of psychotherapy. We do one to one like one to one group
55. with the patients there is a psychologist in the ward and she does a lot of work with the
56. children. We also have an occupational therapist that does a lot of work with them.
57. We also have group session where they sit in the group. We would like get information
58. from them and ask them what are the situations at home and we will get each one of
59. them to share their experiences you know like when children talk and support each
60. other, they feel better about themselves.

61. **Participant:** most of the groups are run by the psychologist, occupational therapist and
their programme is full we try to fit in our nursing groups.

62. **Participant:** the children like to play a lot so we involve them in games to keep them
occupied

63. Interviewer: What level of knowledge and ability is required to perform your duties?

64. Participant: I think being a general psychiatric nurse is sufficient to do my job,

65. however having advanced has taught me so much and had added value to how I perform

66. my duties.

67. Participant: Advance psychiatry

68. Participant: A lot of skills from the advance psychiatric diploma

69. Interviewer: Are you in charge of any project in your ward? If yes which one?

70. Participant: I am just here in fact this is my second week I am still getting familiar

71. with the ward but I plan to do some projects. One of the things that we thought of

72. doing is... a lot of children are reporting a lot of bullying from school so we plan to

73. start programmes and the parenting skills with the parents when they come. A lot of

74. the parents at the out-patients department lack parental skills. One of the sisters that

75. has just started, she and I will run parental skills group. With the children topics like

76. bullying is of them and possible we would like to do outreach programme.

77. Participant: We have asked the unit manager if it is okay on Wednesday because it's

78. our common day if perhaps we can go to schools to go to schools and talk to kids about

79. this type of thing. We also plan to do role plays you know for the kids. It feels like a

80. loss because it feels like you are studying for nothing.

81. Participant: like the two speakers have said we are doing something

82. Interviewer: Are there policies in your ward which guide your practice as an APPN?

83. Participant: No, but we have the Mental Health Care Act and children's Act. Those

84. are the two and I know the children's Act was changed in 2010.

85. Participant: Nope

86. Participant: not that I can think of

87. Interviewer: What are the barriers to the fulfillment of your role?

88. Participant: The barriers that affect fulfillment of my role, I think like in terms of my

89. hospitals are resources. There are not many resources. In this ward for example even

90. though it's a fairly new ward there is no resources. When I talk about resources, I mean

91. art, craft, paper, glitter. The other day I had to run projects with the kids we were

92. making a happy birthday sign we did not have simple thing like glitter. For baking

93. group there is no oven to bake. In terms of nurses not many people are trained with

94. advanced psychiatry here. If you come to the ward there is a lot people think there is

95. not much but there is a lot.

96. Participant: We need to do groups on parenting skills, self-esteem groups and some of

97. the staff is not trained and I think that could also be a hindrance in this unit. Family

98. therapy also is another big issue here when you are expected to do family therapy for

99. people, you have to be knowledgeable. There is also lack of internet access there is

100. computer but staff are not allowed to use it. Sometimes even if you want to do

101. lectures it is difficult to look for information or to download it when you want to do

102. in-service. It's simple things like that that actually can become a problem.

103. Participant: One of the biggest barriers being an APPN that is preventing me from

104. fulfilling my role is that there is no real scope of practice, we do not know what to do

105. , me personally I do not know what to do, what exactly is really expected from me. I

106. did go to Howard Campus; I got the knowledge but sometimes you can't practice it

107. over here. If we have a scope of practice to tell us this is how we differ from the

108. ordinary psychiatric nurse maybe that will be better because right now we just
109. practicing just like a normal registered psychiatric nurse. One of the reasons for
110. doing advance psyche is because I wanted to prosper. I have been working here for
111. 16 years and it feels like I am going nowhere. When they have interviews you not
112. one of the people that are selected. Sometimes you are not even motivated to do the
113. groups because you feel that they got the job, they must run the group. You hope they
114. will know what to do but they keep running to you to find out what you can do. The
115. one in charge do not really use their advanced skills because they are always running
116. meetings. It's a waste having them in the ward since they are not involved in patient
117. care. They are really not here to support us. I did not even get any OSD recognition
118. after I finished the advanced course.

119. **Participant:** I also think that the other barrier is that you are not recognised, I used to
120. sacrifice my Saturdays, paid so much of money to study, I used to sign leave and go
121. on my days off to go and study the advanced psychiatry and when we came back we
122. are not recognized. We were not compensated or paid any money for it. Sometimes
123. you even wonder if it is worth it because when we came back the other staff members
124. was laughing at us saying we fool and we wasted our money and we are not different
125. to anybody else and it's not even worth it. All the girls are not going to do advanced
126. psychiatry because OSD has already been given and having advance psychiatry does
127. not make a difference. Staff shortage is also a problem. There are not many nurses
128. with advance psychiatry so it becomes too much for us because we are expected to do
129. daily routine. We have no time to do projects.

130. **Interviewer: What role do you play in the decision making of patient care**

131. **Participant:** To a certain extent we are involved in decision making but most often

132. the doctors make the decisions regarding the care of the patients. Like in terms of
133. discharge they will say when to discharge, they do ask for our opinion but the onus
134. lies within them.

135. **Participant:** For patient care related we do have a big say. I must say there is a lot
136. of team work here and the nurses have a fair amount of input in the running of the
137. ward.

138. **Participant:** I think our our ward is more specialized and as a result we work as a
139. team . they do realize our input especially now that we have the advance course

140. **Interviewer: What is the current model of care?**

141. **Participant:** In our ward we use both the biomedical and the psychosocial model for
142. the children because when they come in the first week whatever medication they are
143. on from the out-patient department or from the private doctors in this ward we stop all
144. medication to get the true reflection of the client and after that if there is a need we
145. put them on to medication but most often you will find that they don't even need
146. medication. We have two children who were on medication but we have not put
147. them back because they don't need it. They came in with pseudo seizures and in fact
148. because we run groups and them work with the psychologist there was no need. In
149. fact they came with seizures but they have not had any seizures since they came.

150. **Participant:** We also focus a lot on the psychosocial model. We focus on their
151. behaviour, we watch them. We observe the patients and we make them draw a lot of
152. pictures and a lot of them are coming. They do not want to talk about their things.
153. Even though its part of the psychologist's work. We ask them to draw pictures and a

154. lot of pictures will tell you a story even about abuse. We had a case last week where a
155. child was asked to draw the family, she drew her mother and her siblings but when it
156. came to her step father she drew him like a big monster and she drew herself as very
157. tiny and she has a lot aggression in her in behaviour. So yah I will say both
158. biomedical and psychosocial models.
159. **Participant:** We use both in this ward
160. **Interviewer: Does your institution allow you to function as an autonomous**
161. **Individual?**
162. Not really but what I picked up in this ward is that sometimes a person will start a
163. group and it sort falls on the wayside or someone come and takes over and I feel
164. that's what put people off from running the groups.
165. **Participant:** No
166. **Participant:** No. I think the other people here feel like you are taking their job e.g. if
167. you run a group the psychologist will feel you are encroaching into her space. There
168. is still that as if a nurse must keep to nursing duties
169. **Interviewer: Are you able to make decisions regarding implementation of**
170. **health care projects?**
171. **Participant:** No I don't think so especially when you have day and night staff and
172. you have to get everyone on board. But I think you can to a certain extent. The sad
173. thing is that most people do not have advanced psychiatry in this ward.
174. **Participant:** Not really
175. **Participant:** We have no time to do that.

176. Interviewer: Do you have support of the management to effect change?

177. Participant: Hmmm, to a certain extent yes you do have the support of the

178. management. It's a difficult question but not that much

179. Participant: Not at all

180. Participant: Aah no.

181. SESSION 2

182. FOCUS DISCUSSION GROUP 2

183. Interviewer: Good day colleagues

184. Participants: Good day

185. Interviewer: How did it happen that you were allocated to your ward?

186. Participant: It's by allocation; our zone matron allocated us to whichever ward.

187. Participant: Mine was the same I was allocated by the matron's office. We work in

188. the ward for a few months and you are rotated constantly

189. Participant: Same the matron's office does the allocation. I had no choice I was just

190. allocated

191. Interviewer: What type of service is offered in your ward?

192. Participant: The ward that I am working in is a sub-acute ward and psychotherapy.

193. The patients in the ward are not all sub-acute some are still psychotic, restless and

194. agitated. We wait for a while and when they settle and then we send them to the pre-

195. discharge ward.

- 196. Participant:** I work in the acute ward and the patients are psychotic, aggressive,
- 197.** violent, hostile and restless. Also suicidal patients come here we do admissions as
- 198.** well.
- 199. Participant:** I work in the same area ward as the previous speaker and the only thing to add is that it is a male ward
- 200. Interviewer: What are you expected to do on a day to day basis?**
- 201. Participant:** In the morning we take over report from the night staff. In the morning
- 202.** we have our routine where the patients are showered, then they come to the lounge
- 203.** where we do their breakfast, medications. We do orientation, exercises. At about half
- 204.** past nine it's the doctor's rounds. During the doctors round we have the occupational
- 205.** therapist, psychologist, psychiatrist and the nurses, social workers, student nurses and
- 206.** professional nurses.
- 207. Participant:** We delegate the groups that will be done by the students. What we do is
- 208.** that the day before the students are informed about the groups that they need to do.
- 209.** So they prepare and come ready the next day. The staff members as well aware the
- 210.** previous day of the groups which they need to perform the next day. After the groups
- 211.** the patients will have lunch. After lunch those patients who would like to rest
- 212.** go and sleep from half past twelve to half past two. Then the patient will wake up and
- 213.** we teach them about different topics e.g. their rights, OT groups' psychologist group.
- 214.** During the day we will be interviewing our patients and by half past three we have
- 215.** our cardex writing. In the afternoon about five it's supper time for the patients. The

216. patients have games in the afternoon. If there are patients who need to go to other
217. hospitals for investigations or if they are ill then the nurses will do escort duties.
218. **Participant:** Well for me the morning is mainly administration because I form part
219. of management. After that I delegate duties to the staff members whatever
220. programmes that need to be done. We have the professional nurse who will run the
221. groups but he does not run it he delegates. There are lot of meetings that we have to
222. attend from time to time. These meetings take us away from our patients so you find
223. that the person who is with the patients most of the time is other staff members who
224. do not have advance psychiatry. Even if you want to start something you can't follow
225. it through as administration takes a lot of our time. We also have doctor's rounds. We
226. also have morning teaching for patients. If we have orientation with the patient's
227. orientation we also have students to teach and one to one with the patients. The
228. routine is almost the same with the other wards even though the activities might be
229. different depending on the type of patients that we have at a given time. In my ward
230. the routine is pretty much the same except that being an admission ward between
231. 12pm and 6pm admissions are done to the wards depending on the number of beds
232. that we have. This keeps the ward quite busy as more time is taken by admission
233. and calming the admitted clients.

234. **Interviewer:** What are psychotherapeutic interventions that are conducted in your ward?

235. **Participant:** In our ward we are using CBT but not with all the patients. There are

236. few that are good candidates that we use it on and it is working. When it comes to
237. teaching I think it does not work well with our patients because they are have a short
238. attention span therefore unable to concentrate. What we have decided that works
239. better for us we take those patients who have insights into their condition can cope
240. and instead of teaching, we talk about our lives. We talk about the signs and
241. symptoms. We have like a support group, a peer support and it seems to be working
242. because we put in the group that do not have insight and as they talk they begin to
243. understand their problem much better. The patients seem to respond more to each
244. other. We also have anger management groups where patients teach other patients
245. e.g. if you are angry at home how do you deals with it and the patients tell us their
246. experiences because I believe if patients teach each other and works much better. The
247. patients seem to learn more from each other and they are more calm and manageable.
248. They also seem to build this rapport among each other In our ward it is quite difficult
249. to conduct certain groups, but we do allow the patients to narrate their story because
250. that's all they will like to do no matter how aggressive or psychotic they are they all
251. want to tell their own story. So that's where we are winning but in other aspects its
difficult I must say.

252. **Participant:** Our ward we have acutely ill patients so our main objective is to calm
253. them. there isn't much psychotherapy but we do orientation groups. Most of them
254. are too sick to participate in anything so we just manage them accordingly
255. **Participant:** We do a lot of behaviour modifications but like the previous speaker
256. sais our patients are still too sick

257. **Interviewer:** What level of knowledge and ability is required to perform your
258. duties?

259. **Participant:** Administration seem to be appropriate for us in a practical point of
260. view, although some people feel that it is not necessary to have but having done it, I
261. can see value in it. The other knowledge we need to have relate to the policies and
262. procedures of the department because that's what guides us.

263. **Participant:** Our clinical knowledge because I am the ward manager I still need to
264. know what is going on in the wars in terms of the patient and the staff members will
265. still come to me when they are unsure of what decisions to take. Having knowledge
266. from advanced psychiatry is also beneficial because it has helped us to change certain
267. areas in our nursing. We look at things differently now as opposed to before. e.g. the
268. assessment of patients. Previously we used to follow the basic MSE and it was
269. sufficient for us. It is obvious that it is not enough. We used to do the MSE before
270. and not do anything afterwards in terms of planning the intervention on how to care
271. for the client. Our care plans have always been generic in nature. We used to have
272. even drawn up care plans that we used just to photocopy and put into patients files. We
do not do that anymore.

273. **Participant:** I think for us with advanced psychiatry we teaching more about research
274. and we do use it. We did not bother previously; the doctor will instruct to do this and
275. that and will just do it without questioning. But now we are able to give input to
276. patient care during ward rounds and the doctors do listen to us. I now have

277. confidence when approaching consultant's rounds. We have suggestions and input to

278. the care of the patients. We feel we are functioning at a higher level than a general

279. psychiatric nurse.

280. **Interviewer: Are you in charge of any project in your ward? If yes which one?**

281. **Participant:** Presently we started this narrative therapy. We changed it completely

282. from a nurse being a complete dictator now the patients have a say. We used to just

283. go and teach whether the patients understood or not was not necessary. The peer

284. support has helped a lot but we still have staff though who still want to lecture to the

285. patients who can't let go but we are hoping that with time they will learn and give

286. patient more freedom to manage their life.

287. **Participant:** I am not in charge of any project but I am part of a team that is doing

288. something. There is a project that has been presented to management. It's a risk

289. assessment and management programme. It's been running basically covers the

290. aggressive patient, the suicidal, abscondment and assessment of the patients.

291. **Participant:** No

292. **Interviewer: Are there policies in your ward which guide your practice as an**

293. **APPN?**

294. **Participant:** No. I suppose because there is scope of practice. I think the

295. programme that we have worked on does provide some guidelines for practice.

296. **Participant:** No

297. **Participant:** To think of it we have no guidelines

298. **Interviewer: What are the barriers to the fulfillment of your role?**

299. **Participant:** Rotation of staff I think this is our main concern. We orientate the
300. staff and teach them everything only to find that they rotated and new staff comes.
301. The continuity of nursing care is disturbed. Then you find new staff with resistance
302. and whatever you do it's like staring all over again because everybody is gone. The
303. other thing is our research it's very hard as there are no resources. We don't even
304. have access to the intranet or internet, no computers at all. Even if you want to do
305. something you have to beg and it delays the whole process.

306. **Participant:** I think that there is a lack of knowledge on the management side about
307. what advance psychiatry is and what we should be doing I think from the
308. management point of view they do not know much about advanced psychiatry. So
309. when you put ideas forward because we have put our proposal forward but as much as
310. we have got permission to pilot it, we haven't got the support that we need especially
311. in terms of the rotation of staff. I think that there is a lack of knowledge on the
312. management side about what advance psychiatry is and what we should be doing. I
313. think management think that advanced psychiatry is just doing PSR. That makes me
314. feel frustrated and demotivated. You know we need the management to do it so they
315. will understand what needs to be done. Otherwise you will always have a stumbling
316. block. Unless they do it there is no hope.

317. **Participant:** There are not many of us with advance psychiatry so it's difficult to do
318. some project and other PN feel you have the qualification so you must do the job.
319. Like in my ward I am the only one who has advanced psychiatry and to get people to

320. change it's difficult. What makes it worse is the OSD one will find out two PN will
321. be at the same level academically and not financially. And this has created a lot of
322. problems. It becomes a problem as to who takes charge that is responsible for what?
323. This becomes an area of conflict.
324. **Interviewer: What role do you play in the decision making of patient care?**
325. **Participant:** We actually have a good team of MDT. We sit together and make
326. decisions regarding patient care. We actually sit together and solve problem regarding
327. patient care. Even when we need to refer the patient and if we feel there is a need to
328. refer the patients we do refer them.
329. **Participant:** I give valuable input to the MDT about the progress of the patient and
330. make recommendation which are usually accepted
331. **Participant:** Because we know the patients better the other members of the MDT are
332. willing to listen to our suggestions and the knowledge and skill from our course has
333. been very instrumental in giving us the acceptance of our fellow practitioners
334. **Interviewer: What is the current model of care?**
335. **Participant:** It's the Biomedical.
336. We are though trying to shift but haven't made much progress.
337. **Participant:** Mainly biomedical
338. **Participant:** I am sorry to say but biomedical
339. **Interviewer: Does your institution allow you to function as an autonomous individual?**

340. **Participant:** No, never
341. **Participant:** We make decisions as MDT
342. **Participant:** Its team work
343. **Interviewer:** Are you able to make decisions regarding implementation of health
344. care projects?
345. **Participant:** I would say talking from our experience as in trying to implement this
346. risk programme of ours, when we put the idea forward it was accepted very readily.
347. The only obstacle is that of allocation we don't seem to be winning in this area.
348. That's the support that we really need because you find that the people that have
349. researched and developed the programme are the advanced professional nurse. We
350. cannot do research, develop and implement the programme ourselves. We need to
351. teach the general stream PN how to conduct some of the assessments and it will come
352. to us and we will then send it to for interpretation depending on the management of
353. the patient.
354. **Participant:** What we have found is that because of the rotation of staff we fall back
355. on the programme because we have to re-teach the same thing all over again. You
356. have to again get people to buy in. In terms of support this is the area where we really
357. lacking.
358. **Participant:** I also feel that it is difficult to initiate projects if you have no resources
359. **Interviewer:** Do you have support of the management to effect change?
360. **Participant:** We have no support from our management

361. **Participant:** Our management I think does not understand the importance of having
362. equipment like computers in the ward. They don't realize that to do research a person
363. need internet. They think we need internet for our personal use
364. **Participant:** No support at all
365. **SESSION 3**
366. **FOCUS GROUP DISCUSSION 3**
367. **Interviewer: How did it happen that you were allocated to your ward?**
368. **Participant:** We are allocated by the nursing administration so it was by no choice of
369. ours we were just allocated.
370. **Participant:** Like the first speaker we had no choice were just allocated by the
371. matron's office.
372. **Participant:** I was allocated by the matron's office
373. **Interviewer: What type of service is offered in your ward?**
374. **Participant:** I am in acute female admission so we admit acutely ill females for
375. treatment and stabilization. We also run the ECT department as part of our
376. services. Our ward deals with the sub-acute and pre-discharge female patients. We
377. don't have a separate facility for pre-discharge patients so we have the two categories
378. of patients in the same ward.
379. **Participant:** My ward deal with sub-acute male patients also deals with psycho
380. rehabilitation and pre-discharge. My ward deals with the acute male admissions that
381. are brought here after 72 hours holding in the District hospitals. They are stabilized

382. and then moved to the sub-acute ward.

383. **Interviewer: What are you expected to do on a day to day basis?**

384. **Participant:** Our daily routine basically goes around assisting the patients with their

385. basic needs, personal hygiene, eating. Beyond that we assist with the doctor's rounds

386. in terms of giving feedback about the patient's condition. We administer medication

387. to the patients. We also run programmes where we educate patients about their

388. mental condition. We break it up into psycho education as well as health education.

389. And then we do other diversional activities patients so that it assists in passing their

390. day. It's more or less the same it's just that the activities might be slightly different.

391. It depends on how much they have improved from the acute ward, so we build on

392. that.

393. **Participant:** We also deal with discharge so we have a lot of preparation about the

394. patient's discharge planning. Family interventions because we are arranging follow

395. up care for the patient. It's pretty much the same as the first two speakers. We also

396. have our groups.

397. **Participant:** The daily routine will be the same but group wise we have a lot of

398. the psychotherapy a bit of discharge planning, social skills training. We also have a

399. lot of intervention by the psychologist and the occupational therapist during the day

400. Here in the acute ward it's to keep them living and to observe them closely. Address

401. all their needs, physical, nutritional. We also start psycho social rehabilitation. We

402. do a variety of groups, discharge planning. We do psycho-education, social skills.

403. We do not have much intervention by the psychologist but where there is a need they
404. come in. We also have an occupational therapist who works here. Most of our
405. patients are well enough to leave the ward and join the activities like the soccer, and
406. we watch them closely for their potential for aggression and we do risk management
407. with them.

408. **Interviewer: What are psychotherapeutic interventions that are conducted in your ward?**

409. **Participant:** We do not do much psychotherapy. I suppose you could differentiate it,
410. it's not pure psychotherapy that you would have done at North park but we do have a
411. bit of intervention by the psychologist. She does a lot of that kind of therapy. CBT
412. we have not done that formally. Definitely in an acute ward unless there is a specific
413. patient presenting with aggression. Where it is part of the plan or prescribed for the
414. patient but it's formally for all the patients.

415. **Participant:** We are still more at educating then we will refer them to North-park
416. should they need intensive intervention such as CBT. This is psychologist work
417. because we are not formally trained

418. **Interviewer: What level of knowledge and ability is required to perform your
419. Duties?**

420. **Participant:** I think you have to be formally trained. As nurses we do require
421. different categories of staff i.e. professional nurses, staff nurses and nursing assistants.
422. Those levels of training are required. You need people that are trained because to run

423. these programmes you need people who have confidence in saying that we can steer
424. our programmes in this direction. It is not true that we do not need a lot of
425. professional nurses because we do require professional nurses because they got the
426. basis training in psychiatry. You know not to say that we do not need nursing
427. assistants but when it comes to the interventions they feel a bit lost.

428. **Participant:** So we do need people that are trained in psychiatry. To still steer the
429. people who are trained with just psychiatry we need people with advance psychiatry
430. to co-ordinate and put the programmes together and be that people who is steering and
431. leading the projects. You need the core of psychiatric professional nurses who
432. understands the project and as for ENA's this becomes too much. I feels that
433. ultimately all the registered psychiatric nurses should do the advanced psychiatric
434. course and the 6 months training is not adequate to give them in-depth understanding
435. of the mental conditions and the therapies.

436. **Participant:** Maybe we do not do much of these therapies because there are not
437. enough people with knowledge to carry them out. And if these nurses are trained and
438. have advanced psychiatry I think we could fit lot in than we do now. Like our
439. nursing assistants have no psychiatry at all. I think it is important for them to have
440. something. For me is all the RNs have advanced psychiatry it will be very good.

441. **Participant:** You need people that Because you are busy with the paper work in
442. such a way that you do not find time to spend time with individual patients which is
443. very wrong. Because most of the people with advanced psychiatry are managers so

444. they time is being taken up by admin work.
445. **Interviewer: Are you in charge of any project in your ward? If yes which one?**
446. **Participant:** I cannot say in charge but we all have projects that are running. We
447. work together with the staff so that it becomes a team work instead of an individual
448. project. I would not say in charge but thriving towards success
449. **Participant:** I think we do all specific programmes aiming at moving the service
450. forward and improving patient care. I think all of us are driving one programme or
451. another.
452. **Participant:** We are dealing with risk management and suicide risk. But you cannot
453. do it on your own. You need everyone to understand what is happening. There are
454. always on-going projects. Just pushing groups you don't have ... there is a little bit
455. that they are taught in running groups in training. For the students they only about
456. group work only when the lecturers are coming to supervise them after that it is
457. forgotten. They are not interested at all. It's an on-going process to bring the
458. importance of groups to people. I think it's not about starting the programme but
459. about sustaining it, because you will start a programme and you find other things
460. filtering into it then it becomes very difficult to sustain it. Like lack of interest from
461. the staff members, frequent rotation of staff.
462. **Interviewer: Are there policies in your ward which guide your practice as an**
463. **APPN?**
464. **Participant:** NoNoNo Not specially for the advanced psychiatry

465. **Participant:** Not at all
466. **Participant:** No
467. **Interviewer:** What are the barriers to the fulfilment of your role?
468. **Participant:** As an advance practitioner it is difficult to sustain whatever you start.
469. Most wards have minimum of two APPN and that's if you are lucky. So it's very hard
470. to find that person who will run the daily routine and all the things that filter into the
471. day plus do the projects.
472. **Participant:** Here in this ward the plan is to assessment of the patients and put them
473. into different programmes, but it takes like one person just to that only, leaving out
474. the doctor's round medications. So the shortage of staff and the lack of staff with
475. advanced training.
476. **Participant:** I think it's rotation of staff, disinterest and lack of allocation of staff to
477. areas where they will prefer to work at. I think its lack of resources because even if
478. you want to do something e.g. search for data using the internet, there are no
479. computers. Also the fact that there is no scope of practice, you find that like there is
480. no structure. We've done the course years back and you find that those that did it
481. recently... you find that what they know we might not have necessary covered it
482. during our training. That also can be a problem because we are talking in different
483. languages.
484. **Participant:** This not having a scope of practice or a guideline just to say that
485. because I remember when we were training the view that we has was that we were

486. going to be in a consultative role where you will go and around the ward and see what
487. programmes are they doing and how we can assist them. It was like we were not
488. going to be pressed down to the activities of the ward. Which is what happened
489. because most of us we ended up here in the management positions where we still have
490. to do admin responsibilities which cut into the time that you could dedicate to
491. working as an advance practitioner and I think that is why it took us so long to like get
492. things off the ground. It is also that there is no one ahead to actually show us the way
493. we are the front and we do not have much encouragement from our management
494. because it is ... there are no role models or mentors to show us the way. We are
495. working ... we are leaning on each other we bounce thing to each other. If we had a
496. group of advanced practitioners that was functioning, we have nothing to look at we
497. have not benchmark. We doing the best we can and it just by trial and error that we
498. succeed. We would like to have an update so that we are on par with the recently
499. trained advanced practitioners.

500. **Interviewer: What role do you play in the decision making of patient care?**

501. **Participant:** We do have an active role to input the changes in the treatment of our
502. patients. I think it is limited to that but it is left with the medical staff to change the
503. treatment of the patient, but they do consult us. I think it is largely dependent on who
504. you have in your ward at a given time. We are fortunate that we have had our M.O.
505. there for a very long time and we have built a relationship. It does become hard with
506. the changes with the staff when they come and go.

507. **Participant:** I think we do have a significant contribution to patient care I think we
508. have allowed that to happen to us. The structure has changed for the doctor to be at
509. the top of the hierarchy but as nurses we are refusing to work threat needs a
510. psychologist there is nothing stopping me from referring the patient, but we feel that it
511. is the doctor's responsibility to do that. I mean we should be now MDT and be on par
with each other since we all have something to add.

512. **Participant:** For me I feel we should be doing that but we are not allowing ourselves.
513. We carry influence but we do not have authority. It also complicated because we get
514. different doctors coming in. Sometimes we get the doctors who do not understand
515. what the nurses go through and have expectations and those that feel that you are
516. putting your nose into their domain. Our input is valued more now than it was
517. previously.

518. **Interviewer: What is the current model of care?**

519. **Participant:** The biomedical model is what is often used but I do not want to rule out
520. the psychobiocial model because we do use it. I would say it's a mixture of both. It's
521. is the doctor's mind-set that we are using mainly the biomedical model. I think they
522. can't just shift. We found that in the ward round because previously we will have all
523. the members of the team discussing the patient but now you only find the psychiatrist
524. discussing the patient's treatment.

525. **Participant:** The biomedical model

526. **Participant:** Same

527. **Interviewer:** Does your institution allow you to function as an autonomous
528. **Individual?**
529. **Participant:** No. We work together with the doctor who is charge of our department.
530. **Participant:** I think he has learnt to trust us because now that we have done advanced
531. psychiatry we are more knowledgeable and we give valuable input to the MDT
532. **Participant:** not really but we use team work
533. **Interviewer:** Are you able to make decisions regarding implementation
534. of health care projects?
535. **Participant:** We are as long as you don't need anything from anyone.
536. **Participant:** But if it requires resources forget about it.
537. **Participant:** No
538. **Interviewer:** Do you have support of the management to effect change?
539. **Participant:** It will depend on the change that you will want to effect. I think they
540. have tried but they could be more.
541. **Participant:** Depends on the project because you are told you have the skills now just
542. go and do whatever you are planning to do.
543. **Participant:** I think you have more the permission than the support, because the
544. support that you get is limited to the project at hand.
545. **SESSION 4**
546. **FOCUS GROUP DISCUSSION 4**
547. **Interviewer:** How did it happen that you were allocated to your ward?

548. **Participant:** I did mental health nursing after which I applied and I got the post.
549. **Participant:** As for me I have been working in the psychiatric hospital for the past
550. twenty years. When I saw the opportunity that was available I decided to apply
551. for the post that I am in having the passion in psychiatry
552. **Participant:** I applied for the post
553. **Interviewer: What type of service is offered in this hospital?**
554. **Participant:** Acute mental health services
555. **Participant:** it's an acute hospital
556. **Participant:** This is a specialized hospital and it caters for mental health care users
557. who are acutely ill
558. **Interviewer: What are you expected to do on a day to day basis?**
559. **Participant:** To supervise the units which fall under my direct supervision? Actually
560. checking programmes that the ward staff members are actually doing pertaining to
561. patients ranging to so many. For the sub-acute we have programmes like psycho-
562. educational therapy in conjunction with the therapist whereby we involved the
563. patients as well as the family because we are preparing these patients for discharge.
564. We see to it that these programmes are being implemented accordingly.
565. **Participant:** In the acute services we are actually the core of the institution being the
566. first stages of the user so the services that are offered its administration mostly,
567. research and teaching because we have university learners, medical school nursing
568. from the institutions therefore we also teach as well.

569. **Participant:** We work in collaboration with the psychologist, psychiatrist, and the
570. advance nurses we have to be seen as moving towards a specialist hospital. We take
571. care of the KZN in Toto in terms of the patients that come to us. We are the ICU of
572. the institution so to speak.

573. **Interviewer:** What are psychotherapeutic interventions that are conducted in your
departments?

574. **Participant:** They are acutely ill as you know that they are acutely ill you have to do
575. psychotherapy, give them medication so that they can carry on at home. We prepare
576. them for functioning in the community as they come from the community, from the
577. school, from the work-place. We prepare them for going back to their families so that
578. they come to terms with different conditions, in group form, individual therapy and
579. there is something that was started last year where we have families involved so that
580. when they get back they are not appalled by the behaviours that the patients present
581. with. It also a unit which caters for first episode cases which is called North park
582. whereby there are programmes mainly for psychotherapy where they do behaviour
583. modification. The main people that are running the groups are the psychologists as
584. well as the advanced psychiatric nurses.

585. **Participant:** It all depends on the wards and the type of patients some the staff cannot
586. do much psychotherapy with them

587. **Participant:** In my departments the nurses are doing basic nursing since the patients
588. are frail and psychotherapy is not a choice of treatment for them.

589. **Interviewer:** What level of knowledge and ability is required to perform your
590. duties?
591. **Participant:** Well academically as a manager you need to have administration, basic
592. psychiatry and the advance psychiatry which is a requirement since this is a tertiary
593. institution.
594. **Participant:** Human resource management, nursing education and advance
595. Psychiatry
596. **Participant:** I think nursing administration and diploma in psychiatry is sufficient for
597. my position
598. **Interviewer:** Are you in charge of any project in your department? If yes which one?
599. **Participant:** No what we actually do is to see that the projects are actually run
600. because before they implement those projects they actually present them to us to see if
601. there are any gaps that we can identify and rectify them before the implementation of
602. the programme.
603. **Participant:** We oversee that the programmes are run accordingly.
604. Our duty is to supervise the staff to ensure that programs are done. I am not aware of
605. any projects been run in my departments
606. **Interviewer:** Are there policies in your department which guide your practice as
607. an APPN?
608. **Participant:** No

609. **Participant:** No
610. **Participant:** No
611. **Interviewer:** What are the barriers to the fulfilment of your role?
612. **Participant:** It's actually the environment for the sorting out of the institution.
613. Because in terms of the risk management programme we wanted the sorting which is
614. not possible because of parameters you cannot do your risk management. Although
615. you do the risk management, your first episode but it not possible to follow through.
616. **Participant:** One of the thorny issues in practising as an advanced practitioner is that
617. the actual body that governs nursing haven't got the scope of practice in place for the
618. advanced psychiatric nurses
619. **Participant:** there is no scope of practice which guides the practice of the advance
620. practitioner. So it is difficult to hold the nurses responsible for their responsibilities
621. if it is not in their job description.
622. **Interviewer:** What role do you play in the decision making of patient care?
623. **Participant:** Our involvement is when there are problematic cases which need to be
624. discussed. We have a platform where we can exercise our rights it's called the
625. clinical meeting whereby such cases are discussed and we have an effect to the
626. decisions that are being taken by them. That's the forum where we address problems
627. that adversely affect the as well as in the institution in portraying the organizational
628. work from that complements the mhcu the problems that they encounter in their care
629. because we have to consider their welfare while they are still in the institution.

630. **Participant:** The supervision is the core where we have to guide and monitor and
631. check if it's all happening after your guidance.
632. **Participant:** It is our responsibility to audit of the patients files to ensure that quality
633. care is given. This gives us decision making powers on how the health care standards
634. should be
635. **Interviewer: What is the current model of care?**
636. **Participant:** We used both biomedical model and psychosocial model
637. **Participant:** I think we use biomedical model more
638. **Participant:** Biomedical model
639. **Interviewer: Does your institution allow you to function as an autonomous**
640. **individual?**
641. **Participant:** As it should be as the advanced practitioner but our powers are limited
642. in such a way that we may have to rely on the old model of our intervention where by
643. the ultimate authorities lie within the doctors. That's the other problem with the
644. advanced practitioner that we are allowed to prescribe.
645. **Participant:** In my capacity as an assistant manager I am able to take decisions
646. regarding the functioning of my departments. There are circumstances when I need to
647. consult. As an advance practitioner I don't have much say as I am not directly
648. involved in the care of patients
649. **Participant:** Sometimes as the last speaker stated
650. **Interviewer: Are you able to make decisions regarding implementation of health**

651. **care projects?**

652. **Participant:** This is a difficult question because the advance nurses are the one

653. that should initiate the projects and my duty is just supervision

654. **Participant:** We are not directly involved in the implementation of the projects

655. **Participant:** Not really

656. Do you as the management support the staff members to effect change?

657. **Participant:** A lot without a doubt. We provide them with whatever is at our

658. disposal, we make sure that it is available to them.

659. **Participant:** We do give them a lot of support as long as they ask for it. The problem

660. is that the nurses are not keen on doing projects so they hardly ask for support

661. Well shortage of resource is a big problem we are trying all we can to make

662. motivation to get more equipment.

663. **Participant:** We do support the staff members it's just that they don't make their

664. requisition on time because you see these things involve cash flow decisions.

665. **SESSION5**

666. **FOCUS GROUP DISCUSSION 5**

667. **Interviewer: How did it happen that you were allocated to your**

668. **ward?**

669. **Participant:** I was just allocated by the nursing administration; I really had no say in

670. the matter

671. **Participant:** Same as the previous speaker. We get allocated in whatever ward we

672. have no choice

673. **Interviewer: What type of service is offered in your ward?**

674. **Participant:** We are female psycho-geriatric unit and we offer nursing to the geriatric

675. patients holistically because most of them have a lot more of physical problems. We

676. also see a lot of Alzheimer's disease and dementia. That's what most of our patients

677. suffer from and we have chronic mental conditions like Schizophrenia who are long

678. term and cannot be placed back to the society.

679. **Participant:** My ward is almost the same except that it is a male psychogeriatric

680. ward. Most of our patients have grown in this hospital they were admitted when they

681. were fairly young. Some of the patients suffer from dementia related to use of

682. substance abuse

683. **Interviewer: What are you expected to do on a day to day basis?**

684. **Participant:** As I was saying because with the Dementia it's degenerative so what is

685. expected is that beside their mental illness where we have to monitor their

686. disorientation, confusion and deal with it and have to assist with the activities of daily

687. living and that takes up the bulk of our time. For the rest of the day we involve the

688. mental health care user in simple activities because of the level of functioning and

689. their concentration span which is very short and their memory which is poor so we

690. involve them in basic activities.

691. **Participant:** Reality orientation is the main one, and then simple exercises and then

692. simple games which are not taxing to their memory which they can do in the short

693. space of time. Other than that it's just seeing to their basic needs e.g. personal
694. hygiene, nutrition. We also assess them for risk of falling because as I said some of
695. them are getting frail with the age.
696. **Interviewer: What are psychotherapeutic interventions that are conducted in**
697. **your ward?**
698. **Participant:** We don't do a lot. Sometimes we have patients that require behaviour
699. modification but not all the time. But we do get them especially with the assessment
700. patients and we do when it is warranted for those patient.
701. **Participant:** Our patients are old and just need tender love and care.
702. **Interviewer: What level of knowledge and ability is required to perform your**
703. **duties?**
704. **Participant:** The basic psychiatric course
705. **Participant:** I think advance psychiatry is important for me it has changed the way I
706. look at nursing care. The skills are important and I try to teach other staff members if
707. I have a chance Interviewer:
708. **Are you in charge of any project in your ward? If yes which one?**
709. **Participant:** As I am saying we've done the risk assessment project which is
710. specifically to the geriatric ward for risk assessment that all our patients need to be
711. assessed specifically for these ward and we feel that the community is not aware of
712. the service for geriatric patient and that's what we are doing at the moment.
713. **Participant:** We are working on a programme of community outreach to involve

714. them because they think when the patients get admitted here they are going to get

715. better and what they don't understand is that you cannot reverse the degenerative

716. process. So we are embarking on the education of the community.

717. **Interviewer: Are there policies in your ward which guide your practice as an**

718. **APPN?**

719. **Participant:** There are no guidelines.

720. **Participant:** No direction at all

721. **Interviewer: What are the barriers to the fulfillment of your role?**

722. **Participant:** I think we need support so that when you come up with programmes we

723. get support. I think also that our management are not sure of what we as advanced

724. psychiatric practitioners are supposed to be doing. That is why we do not get much

725. support. We initiate the programmes but if you do not get support you cannot

726. progress.

727. **Participant:** We need policies, we need a scope of practice and we need guidelines

728. and we would be able to function more effectively. It is very difficult for us not

729. knowing what to do. We are also at different level of understanding as advance

730. nurses. We need updates to keep us informed because I tell I think the ones who

731. studied in Durban know more than us. So there is that knowledge gap

732. **Interviewer: What role do you play in the decision making of patient care**

733. **Participant:** I would say a big role because I am part of the multidisciplinary team in

734. the ward and I play a big role in the decision making of patient care.

735. **Participant:** I would say that the other staff members understand the patients better.
736. Most of the time we are at meetings or doing admin work. But I do make
737. recommendations to the MDT based on the information from my colleagues
738. **Interviewer: What is the current model of care?**
739. **Participant:** The biomedical model
740. **Participant:** The biomedical model even though most of our patients are just on
741. vitamin tablets
742. **Interviewer: Does your institution allow you to function as an autonomous**
743. **individual?**
744. **Participant:** No
745. **Participant:** never. I think it will take some time for us to reach that level, but we do
746. have a good MDT that we work hand in hand with. The doctors take us
747. seriously now that we have advance diploma. They listen to us more
748. **Interviewer: Are you able to make decisions regarding implementation of health**
749. **care projects?**
750. **Participant:** No, we can initiate but someone else will take a decision of whether or
751. not to implement
752. **Participant:** There is really no support there. You see the management have to be
753. 100% behind us when we do that. We have ideas for example to do community
754. education but we can't do that because who is going to run the ward . sometimes it's
755. better to take the information to the community but with the shortage of staff that is

756. not possible
757. **Interviewer: Do you have support of the management to effect change?**
758. **Participant:** Aaah, no.
759. **Participant:** Like I said before no.
760. **SESSSION**
761. **Interviewer:** Good afternoon members
762. **Participants:** Good afternoon
763. **Interviewer: How did it happen that you are member of the selection**
764. **committee?**
765. **Participant:** As the assistant nursing manager I was elected to be part of the selection
766. process to see that procedures are followed
767. **Participant:** I am in charge of in-service training so I was elected to the selection
768. committee to help facilitate the process
769. **Interviewer: Do you have the indicators or tools that you are using to determine**
770. **the effectiveness of APPN in the provision of care?**
771. **Participant:** There are no indicators or tools at all
772. **Participant:** No there are no guidelines as such but we rely on the job description
773. which does not say much about advance nursing
774. **Interviewer: What behaviour do you perceive to characterize an APPN?**
775. **Participant:** I expect the advance nurse practitioner to be able to develop
776. programmes specific to the patients that they are nursing, depending on the type of

777. patients. Things like.... It's more different in a psychotherapy ward if you have the
778. first episodes and you know sort of programmes like risk management in the acute,
779. and it's not everybody that is doing it. Certain specified nursing staff with specific
780. skills.

781. **Participant:** I should think its strong leadership skills. As they have been to Howard
782. through the advanced training therefore I would expect them to take a leadership role
783. in the ward and patient care and patient management. They should be able to develop
784. programmes and also be able to demonstrate a very strong teaching role in the wards
785. because of their increased knowledge and broader knowledge range gained, they
786. really be teaching the other staff and helping them to expand their knowledge.

787. **Interviewer: What are your expectations? Have your expectations been met?**

788. **Participant:** I expect them to function at a higher level and be exemplary in their
789. practice. They should conduct is-service education for staff members.

790. **Participant:** I also expect them to use their knowledge in the development of
791. projects. They should really stand out in their practice.

792. **Participant:** To answer your second question, the expectations have been met
793. partially because they still working on some of the programmes. Some we are
794. piloting but some have been successful.

795. **Participant:** I don't know that I can say they have not been met, in that it is difficult
796. when I am not in the ward to measure what teaching is taking place. There are no
797. programmes that I am aware of or given to say these are the programmes that are

798. being run in the wards. Whether there is or not teaching happening I would not be
799. able to say because I have not been given anything physical to show it but that is not
800. to say that it might not be happening.

801. **Interviewer: What are the barriers for the meeting the expectations?**

802. **Participant:** There are not enough guidelines and there is no scope of practice. The
803. absence of the scope of practice from the nursing council point of view makes it is
804. very difficult for the nursing management to develop a scope of practice therefore
805. they do not have anything to formulate their practice on in the ward.

806. **Participant:** We envisage what we would like to see them doing but we are blocked
807. by the lack of scope of practice. If there is no scope of practice that is guiding them
808. clearly as what to do it's only to rely on their Job descriptions which we have asked
809. them to make them a little bit different so that they include the programmes that they
810. are running in the department.

811. **Interviewer: Do you as management support staff to effect change?**

812. **Participant:** I would say they are given support because if they are giving a request
813. in writing and writing down whatever motivation and the programme that they want
814. to run, it has never been turn down because we need to see the way forward.

815. **Participant:** I believe that anything that they would come up with that they would
816. like that is proactive would be happily welcomed and supported by management but
817. at the moment I have not seen any request

ANNEXURE L

RAW DATA

This section is the working document the researcher used to identify the emergent themes. The researcher organized the data by formulating the codes for her easy understanding. The data collected from participants was made italic. As the themes were identified, the researcher wrote them in capital letters to denote their significance and used different colours to code different themes. This made it easy to see the emergent themes at a glance thus saving time. The questions from the researcher were left in the normal writing but bolded them for readability and to differentiate from the participants responses. This process is referred to as editing approach since it is much as an editor does while making interpretative statements during the process of identifying patterns for organizing text (DiCicco-Bloom & Crabtree, 2006).

10. How did it happen that you were allocated to your ward?

I was allocated to the child assessment unit because I've got advanced psychiatry and we were actually asked to actually say which ward we would like to work in and one of the wards that I chose was CAU and that is how I was allocated here.

11. What type of service is offered in your ward?

As I said this is a child assessment unit we do a lot of rehabilitation, group therapies and we concentrate more on the social aspect of the child. Most of the time we deal with the disability grant, a lot of problems and sometimes there will be rape cases that we will need to refer to the psychologist that type of things. We try and use all the avenues when the child when we are dealing the child and we cater for whatever the child needs. A lot of group therapy, we also even though we are not trained in teaching, we run sessions with the children. When they come in we asked the schools to send in their set books and we do a lot of schoolwork as such with them. If they are doing L.O. we would do that type of subject with them. With their maths aah we will try to make sure that their homework is done. We try and ask the teachers to send their homework with them if is possible and if it's not possible we ask the parents to bring in their set books. We asked the teachers to send homework for them if it's possible. Sometimes we asked the parents to actually get the homework or send the child with their homework. (ROLE OF A NURSE) We

also do a lot of family therapy. The family comes in and actually try and ascertain what the problem is with the children, try to get down to the root of the problem. A lot of therapies and we try and implement of CBT (Cognitive behaviour therapy) and in some children it's not feasible and we also at times if possible do narrative therapy with the children. (MODEL OF CARE) At times we try and get the syllabus from the teacher if we can contact the teacher but we try and get the syllabus from the teachers or most often the children coming with their books so we look at the books and see what they are doing and every in morning from nine to twelve is the school routine and after that we concentrate on the group work.

12. What are you expected to do on a day to day basis?

On a day to day basis we actually when we come on duty we take over from night staff, we make sure that the children have a bath and we see to their basic needs. We see that they have their breakfast and after they have their breakfast as I said from nine o'clock to twelve o'clock they have their schoolwork and after school work it's their lunch. The children are actually encouraged to be active like... they dish out for themselves and they also... they do their schoolwork then their lunch. When they have their lunch they go and they have a rest period from half past twelve to half past two thereafter we do various other groups with the children including whatever is set for the day. (ROLE OF A NURSE) For example today we focus on TB, we did TB health education. We also focus on their age level of whatever age level they are then we do for example menstruation. Three of our children here are from 11-12 years old and they have not yet had their menses. So we also tend to focus on that type of thing to inform them. So we try and concentrate on that type of thing. We also try and do group on self-esteem because most of the children in this department lack self-esteem. We also do whatever is necessary we don't have a formal programme as the unit is fairly new. (GROUPS)

13. What are psychotherapeutic interventions that are conducted in your ward?

What exactly do you mean?

I mean therapeutic interventions like CBT, psychotherapy

We do a lot of psychotherapy. We do one to one like one to one group with the patients there is a psychologists in the ward and she does a lot of work with the children. We also have an occupational therapist that does a lot of work with them. We also have group session where they sit in the group. We would like get information from them and ask them what are the situations at

home and we will get each one of them to share their experiences you know like when children talk and support each other, they feel better about themselves (MODEL OF CARE)

14. What level of knowledge and ability is required to perform your duties?

I think being a general psychiatric nurse is sufficient to do my job, however having advanced has taught me so much and had added value to how I perform my duties. (KNOWLEDGE)

15. Are you in charge of any project in your ward? If yes which one?

I am just here in fact this is my second week I am still getting familiar with the ward but I plan to do some projects. One of the things that we thought of doing is... a lot of children are reporting a lot of bullying from school so we plan to start programmes and the parenting skills with the parents when they come. A lot of the parents at the out-patients department lack parental skills. One of the sisters that has just started, she and I will run parental skills group. With the children topics like bullying is of them and possible we would like to do outreach programme. We have asked the unit manager if it is okay on Wednesday because it's our common day if perhaps we can go to schools to go to schools and talk to kids about this type of thing. We also plan to do role plays you know for the kids. PROJECTS

It feels like a loss because it feels like you are studying for nothing. One of the reasons for doing advance psyche is because I wanted to prosper. I have been working here for 16 years and it feels like I am going nowhere. When they have interviews you not one of the people that are selected. Sometimes you are not even motivated to do the groups because you feel that they got the job, they must run the group.(OSD) You hope they will know what to do but they keep running to you to find out what you can do. They do not really use their advanced skills because they are always running meetings. They are really not here to support us. I did not even get any OSD recognition after I finished the advanced course. (OSD)

16. Are there policies in your ward which guide your practice as an APPN?

No, but we have the Mental Health Care Act and children's Act. Those are the two and I know the children's Act was changed in 2010.

17. What are the barriers to the fulfilment of your role?

The barriers that affect fulfilment of my role, I think like in terms of my hospital are resources. There are not many resources. In this ward for example even though it's a fairly new ward there

is no resources. When I talk about resources, I mean art, craft, paper, glitter. The other day I had to run projects with the kids we were making a happy birthday sign we did not have simple thing like glitter. For baking group there is no oven to bake. In terms of nurses not many people are trained with advanced psychiatry here. If you come to the ward there is a lot people think there is not much but there is a lot. We need to do groups on parenting skills, self esteem groups and some of the staff is not trained and I think that could also be a hindrance in this unit.

LACK OF RESOURCES Family therapy also is another big issue here when you are expected to do family therapy for people, you have to be knowledgeable. There is also lack of internet access there is computer but staff are not allowed to use it. Sometimes even if you want to do lectures it is difficult to look for information or to download it when you want to do in-service. Its simple things like that that actually can become a problem. *One of the biggest barriers being an APPN that is preventing me from fulfilling my role is that there is no real scope of practice, we do not know what to do , me personally I do not know what to do, what exactly is really expected from me. I did go to Howard Campus; I got the knowledge but sometimes you can't practice it over here. If we have a scope of practice to tell us this is how we differ from the ordinary psychiatric nurse maybe that will be better because right now we just practicing just like a normal registered psychiatric nurse.*

SCOPE OF PRACTICE I also think that the other barrier is that you are not recognised, *I used to sacrifice my Saturdays, payed so much of money to study, I used to sign leave and go on my days off to go and study the advanced psychiatry and when we came back we are not recognised. We were not compensated or paid any money for it. Sometimes you even wonder if it is worth it because when we came back the other staff members was laughing at us saying we fool and we wasted our money and we are not different to anybody else and it's not even worth it. All the girls are not going to do advanced psychiatry because OSD has already been given and having advance psychiatry does not make a difference.*

OCCUPATIONAL SPECIFIC DISPENSATION

18. What role do you play in the decision making of patient care

To a certain extent we are involved in decision making but most often the doctors make the decisions regarding the care of the patients. Like in terms of discharge they will say when to discharge, they do ask for our opinion but the onus lies within them. But for patient care related we do have a big say. I must say there is a lot of team work here and the nurses have a fair amount of input in the running of the ward.

- **What is the current model of care?**

MODEL OF CARE) *In our ward we use both the biomedical and the psychosocial model for the children because when they come in the first week whatever medication they are on from the outpatient department or from the private doctors in this ward we stop all medication to get the true reflection of the client and after that if there is a need we put them on to medication but most often you will find that they don't even need medication. We have two children who were on medication but we have not put them back because they don't need it. They came in with pseudo seizures and in fact because we run groups and then work with the psychologist there was no need. In fact they came with seizures but they have not had any seizures since they came. We also focus a lot on the psychosocial model. We focus on their behaviour, we watch them. We observe the patients and we make them draw a lot of pictures and a lot of them are coming. They do not want to talk about their things. Even though it's part of the psychologist's work. We ask them to draw pictures and a lot of pictures will tell you a story even about abuse. We had a case last week where a child was asked to draw the family, she drew her mother and her siblings but when it came to her step father she drew him like a big monster and she drew herself as very tiny and she has a lot aggression in her in behaviour. So yah I will say both biomedical and psychosocial models*

MODEL OF CARE) **Does your institution allow you to function as an autonomous individual?**

Not really but what I picked up in this ward is that sometimes a person will start a group and it sort falls on the wayside or someone come and takes over and I feel that's what put people off from running the groups.

- **Are you able to make decisions regarding implementation of health care projects?**

No I don't think so especially when you have day and night staff and you have to get everyone on board. But I think you can to a certain extent. The sad thing is that most people do not have advanced psychiatry in this ward. At the moment it's just I and the unit manager (AUTONOMY)

- **Do you have support of the management to effect change?**

Hmmm, to a certain extent yes you do have the support of the management. It's a difficult question but not that much (MANAGEMENT SUPPORT)

SESSION 2

FOCUS GROUP

1. How did it happen that you were allocated to your ward?

It's by allocation; our zone matron allocated us to whichever ward.

Mine was the same I was allocated by the matron's office. We work in the ward for a few months and you are rotated constantly

Same the matron's office does the allocation. I had no choice I was just allocated

2. What type of service is offered in your ward?

The ward that I am working in is a sub-acute ward and psychotherapy. The patients in the ward are not all sub-acute some are still psychotic, restless and agitated. We wait for a while and when they settle and then we send them to the pre-discharge ward.

I work in the acute ward and the patients are psychotic, aggressive, violent, hostile and restless. Also suicidal patients come here we do admissions as well.

I work in the same area ward as the previous speaker and the only thing to add is that it is a male ward (MODEL OF CARE)

3. What are you expected to do on a day to day basis?

In the morning we take over report from the night staff. In the morning we have our routine where the patients are showered, then they come to the lounge where we do their breakfast, medications. We do orientation, exercises. At about half past nine it's the doctor's rounds. During the doctors round we have the occupational therapist, psychologist, psychiatrist and the nurses, social workers, student nurses and professional nurses. We delegate the groups that will be done by the students. What we do is that the day before the students are informed about the groups that they need to do. So they prepare and come ready the next day. The staff members as well aware the previous day of the groups which they need to perform the next day. After the groups the patients will have lunch. After lunch those patients who would like to rest go and sleep from half past twelve to half past two. Then the patient will wake up and we teach them about different topics e.g. their rights, OT groups' psychologist group. During the day we will be interviewing our patients and by half past three we have our cardex writing. In the afternoon about five its supper time for the patients. The patients have games in the afternoon. If there are

patients who need to go to other hospitals for investigations or if they are ill then the nurses will do escort duties. (ROLE OF A NURSE)

Well for me the morning is mainly administration because I form part of management. After that I delegate duties to the staff members whatever programmes that need to be done. We have the professional nurse who will run the groups but he does not run it but delegates. There are lot of meetings that we have to attend from time to time. (ADMINISTRATIVE DUTIES) These meetings take us away from our patients so you find that the person who is with the patients most of the time is other staff members who do not have advance psychiatry. Even if you want to start something you can't follow it through as administration takes a lot of our time. We also have doctor's rounds. We also have morning teaching for patients. If we have orientation with the patient's orientation we also have students to teach and one to one with the patients. The routine is almost the same with the other wards even though the activities might be different depending on the type of patients that we have at a given time.

In my ward the routine is pretty much the same except that being an admission ward between 12pm and 6pm admissions are done to the wards depending on the number of beds that we have. This keeps the ward quite busy as more time is taken by admission and calming the admitted clients. (WARD ROUTINE)

4. What are psychotherapeutic interventions (CBT, Psychotherapy) that are conducted in your ward?

In our ward we are using CBT but not with all the patients. There are few that are good candidates that we use it on and it is working. When it comes to teaching I think it does not work well with our patients because they have a short attention span therefore unable to concentrate. What we have decided that works better for us we take those patients who have insights into their condition can cope and instead of teaching, we talk about our lives. We talk about the signs and symptoms. We have like a support group, a peer support and it seems to be working because we put in the group and even those that do not have insight as they talk they begin to understand their problem much better. The patients seem to respond more to each other. We also have anger management groups where patients teach other patients e.g. if you are angry at home how do you deal with it and the patients tell us their experiences because I believe if patients teach each other and works much better. The

patients seem to learn more from each other and they are more calm and manageable. They also seem to build this rapport among each other (MODEL OF CARE)

In our ward it is quite difficult to conduct certain groups, but we do allow the patients to narrate their story because that's all they will like to do no matter how aggressive or psychotic they are they all want to tell their own story. So that's where we are winning but in other aspects its difficult I must say. other (MODEL OF CARE)

5. What level of knowledge and ability is required to perform your duties?

Administration seem to be appropriate for us in a practical point of view, although some people feel that it is not necessary to have but having done it, I can see value in it. The other knowledge we need to have relate to the policies and procedures of the department because that's what guides us. (KNOWLEDGE) Our clinical knowledge because I am the ward manager i still need to know what is going on in the wars in terms of the patient and the staff members will still come to me when they are unsure of what decisions to take. Having knowledge from advanced psychiatry is also beneficial because it has helped us to change certain areas in our nursing. (ADMINISTRATIVE DUTIES) We look at things differently now as opposed to before. e.g. the assessment of patients. Previously we used to follow the basic MSE and it was sufficient for us. It is obvious hat it is not enough. We used to do the MSE before and not do anything afterwards in terms of planning the intervention on how to care for the client. Our care plans have always been generic in nature. We used to have even drawn up care plans that we used just to photocopy and put into patients files. We do not do that anymore. (IMPACT OF THE COURSE)

I think for us with advanced psychiatry we teaching more about research and we do use it. We did not bother previously; the doctor will instruct to do this and that and will just do it without questioning. But now we are able to give input to patient care during ward rounds and the doctors do listen to us. (DEPENDENT)

I now have confidence when approaching consultant's rounds. We have suggestions and input to the care of the patients. We feel we are functioning at a higher level than a general psychiatric nurse. (COLLABORATION)

6. Are you in charge of any project in your ward? If yes which one?

Presently we started this narrative therapy. We changed it completely from a nurse being a complete dictator now the patients have a say. We used to just go and teach whether the patients understood or not was not necessary. The peer support has helped a lot but we still have staff though who still want to lecture to the patients who can't let go but we are hoping that with time they will learn and give patient more freedom to manage their life.

I am not in charge of any project but I am part of a team that is doing something. There is a project that has been presented to management. It's a risk assessment and management programme. It's been running basically covers the aggressive patient, the suicidal, abscondment and assessment of the patients. (PROJECTS)

7. Are there policies in your ward which guide your practice as an APPN?

No. I suppose because there is scope of practice. I think the programme that we have worked on does provide some guidelines for practice. (SCOPE OF PRACTICE)

8. What are the barriers to the fulfilment of your role?

Rotation of staff I think this is our man concern. We orientate the staff and teach them everything only to find that they rotated and new staff comes. The continuity of nursing care is disturbed. Then you find new staff with resistance and whatever you do it's like starting all over again because everybody is gone. The other thing is our research it's very hard as there are no resources. We don't even have access to the intranet or internet, no computers at all. Even if you want to do something you have to beg and it delays the whole process. (STAFF ROTATION resources)

I think from the management point of view they do not know much about advanced psychiatry. So when you put ideas forward because we have put our proposal forward but as much as we have got permission to pilot it, we haven't got the support that we need especially in terms of the rotation of staff. *I think that there is a lack of knowledge on the management side about what advance psychiatry is and what we should be doing. I think management think that advanced psychiatry is just doing PSR. That makes me feel frustrated and demotivated. You know we need the management to do it so they will understand what needs to be done. Otherwise you will always have a stumbling block. Unless they do it there is no hope. (LACK OF KNOWLEDGE)*

There are not many of us with advance psychiatry so its difficult to do some project and other PN feel you have the qualification so you must do the job. Like in my ward I am the only one who

has advanced psychiatry and to get people to change it's difficult. *What makes it worse is the OSD one will find out two PN will be at the same level academically and not financially. And this has created a lot of problems. It becomes a problem as to who takes charge that is responsible for what? This becomes an area of conflict.* **OCCUPATIONAL SPESIFIC DISPENSATION**

9. What role do you play in the decision making of patient care?

We actually have a good team of MDT. We sit together and make decisions regarding patient care. We actually sit together and solve problem regarding patient acre. Even when we need to refer the patient and if we feel there is a need to refer the patients we do refer them

COLLABORATION

• What is the current model of care?

Biomedical model

- Does your institution allow you to function as an autonomous individual?**

No, never

- Are you able to make decisions regarding implementation of health care projects?**

I would say talking from our experience as in trying to implement this risk programme of ours, when we put the idea forward it was accepted very readily. The only obstacle is that of allocation we don't seem to be winning in this area. That's the support that we really need because you find that the people that have researched and developed the programme are the advanced professional nurse. *We cannot though research, develop and implement the programme ourselves. We need to teach the general stream PN how to conduct some of the assessments and it will come to us and we will then send it to for interpretation depending on the management of the patient. What we have found is that because of the rotation of staff we fall back on the programme because we have to re-teach the same thing all over again. You have o*

again get people to buy in. In terms of support this is the area where we really lacking. **STAFF ROTATION/SHORTAGE**

- **Do you have support of the management to effect change?**

SESSION 3

1. How did it happen that you were allocated to your ward?

We are allocated by the nursing administration so it was by no choice of ours we were just allocated.

Like the first speaker we had no choice were just allocated by the matron's office.

I was allocated by the matron's office

2. What type of service is offered in your ward?

I am in acute female admission so we admit acutely ill females for treatment and stabilisation.

We also run the ECT department as part of our services.

Our ward deals with the sub acute and pre-discharge female patients. We don't have a separate facility for pre-discharge patients so we have the two categories of patients in the same ward.

My ward deal with sub acute male patients also deals with psycho rehabilitation and pre-discharge.

My ward deals with the acute male admissions that are brought here after 72 hours holding in the District hospitals. They are stabilized and then moved to the sub acute ward. (TYPE OF

WARD)

3. What are you expected to do on a day to day basis?

Our daily routine basically goes around assisting the patients with their basic needs, personal hygiene, eating. Beyond that we assist with the doctor's rounds in terms of giving feedback about the patient's condition. We administer medication to the patients. We also run programmes where we educate patients about their mental condition. We break it up into psycho education as well as health education. And then we do other diversional activities patients so that it assists in passing their day.

It's more or less the same it's just that the activities might be slightly different. It depends on how much they have improved from the acute ward, so we build on that. We also deal with discharge so we have a lot of preparation about the patient's discharge planning. Family interventions because we are arranging follow up care for the patient (ROLE OF A NURSE)

It's pretty much the same as the first two speakers. We also have our groups. The daily routine will be the same but group wise we have a lot of the psychotherapy a bit of discharge planning, social skills training. We also have a lot of intervention by the psychologist and the occupational therapist during the day. (ROLE OF A NURSE)

Here in the acute ward it's to keep them living and to observe them closely. Address all their needs, physical, nutritional. We also start psycho social rehabilitation. We do a variety of groups, discharge planning. We do psycho-education, social skills. We do not have much intervention by the psychologist but where there is a need they come in. We also have an occupational therapist who works here. Most of our patients are well enough to leave the ward and join the activities like the soccer, and we watch them closely for their potential for aggression and we do risk management with them. (ROLE OF A NURSE)

4. What are psychotherapeutic interventions (CBT, Psychotherapy) that are conducted in your ward?

We do not do much psychotherapy. I suppose you could differentiate it, it's not pure psychotherapy that you would have done at North park but we do have a bit of intervention by the psychologist. She does a lot of that kind of therapy. CBT we have not done that formally (Model of care)

Definitely in an acute ward unless there is a specific patient presenting with aggression. Where it is part of the plan or prescribed for the patient but it's formally for all the patients. We are still more at educating then we will refer them to North park should they need intensive intervention such as CBT (MODEL OF CARE))

This is psychologist work because we are not formally trained

5. What level of knowledge and ability is required to perform your duties?

I think you have to be formally trained. As nurses we do require different categories of staff i.e. professional nurses, staff nurses and nursing assistants. Those levels of training are required.

(KNOWLEDGE)

*You need people that are trained because to run these programmes you need people who have confidence in saying that we can steer our programmes in this direction. It is not true that we do not need a lot of professional nurses because we do require professional nurses because they got the basis training in psychiatry. You know not to say that we do not need nursing assistants but when it comes to the interventions they feel a bit lost. So we do need people that are trained in psychiatry. To still steer the people who trained with just psychiatry we need people with advance psychiatry to co-ordinate and put the programmes together and be that people who is steering and leading the projects. **SHOTRAGE OF STAFF***

You need the core of psychiatric professional nurses who understands the project and as for ENA's this becomes too much.

*I feels that ultimately all the registered psychiatric nurses should do the advanced psychiatric course and the 6 months training is not adequate to give them in-depth understanding of the mental conditions and the therapies. Maybe we do not do much of these therapies because there are not enough people with knowledge to carry them out. And if these nurses are trained and have advanced psychiatry I think we could fit lot in than we do now. Like our nursing assistants have no psychiatry at all. I think it is important for them to have something. For me is all the RNs have advanced psychiatry it will be very good. **SHORTAGE OF STAFF***

You need people that Because you are busy with the paper work in such a way that you do not find time to spend time with individual patients which is very wrong. Because most of the people with advanced psychiatry are managers so they time is being taken up by admin work.

ADMINISTRATIVE DUTIES

6. Are you in charge of any project in your ward? If yes which one?

*I cannot say in charge but we all have projects that are running. We work together with the staff so that it becomes a team work instead of an individual project. I would not say in charge but thriving towards success (**PROJECTS**)*

I think we do all specific programmes aiming at moving the service forward and improving patient care. I think all of us are driving one programme or another.

We are dealing with risk management and suicide risk. But you cannot do it on your own. You need everyone to understand what is happening. There are always on-going projects. Just pushing groups you don't have ... there is a little bit that they are taught in running groups in training. For the students they only about group work only when the lecturers are coming to supervise them after that it is forgotten. They are not interested at all. It's an on-going process to bring the importance of groups to people. (PROJECTS)

I think it's not about starting the programme but about sustaining it, because you will start a programme and you find other things filtering into it then it becomes very difficult to sustain it. Like lack of interest from the staff members, frequent rotation of staff. STAFF ROTATION

7. Are there policies in your ward which guide your practice as an APPN?

No

No

No

Not specially for the advanced psychiatry

8. What are the barriers to the fulfilment of your role?

As an advance practitioner it is difficult to sustain whatever you start. Most wards have minimum of two APPN and that's if you are lucky. So its very hard to find that person who will run the daily routine and all the things that filter into the day plus do the projects. Here in this ward the plan is to assessment of the patients and put them into different programmes, but it takes like one person just to that only, leaving out the doctor's round medications. So the shortage of staff and the lack of staff with advanced training. SHORTAGE OF STAFF

I think it's rotation of staff, disinterest and lack of allocation of staff to areas where they will prefer to work at. STAFF ROTATION

I think its lack of resources because even if you want to do something e.g. search for data using the internet, there are no computers. Also the fact that there is no scope of practice, you find that like there is no structure. We've done the course years back and you find that those that did

it recently... you find that what they know we might not have necessary covered it during our training. That also can be a problem because we are talking in different languages. **LACK OF RESOURCES**

This not having a scope of practice or a guideline just to say that because I remember when we were training the view that we has was that we were going to be in a consultative role where you will go and around the ward and see what programmes are they doing and how we can assist them **(SCOPE OF PRACTICE)**

. It was like we were not going to be pressed down to the activities of the ward. Which is what happened because most of us we ended up here in the management positions where we still have to do admin responsibilities which cut into the time that you could dedicate to working as an advance practitioner and I think that is why it took us so long to like get things off the ground.

ADMINISTRATIVE DUTIES

It is also that there is no one ahead to actually show us the way we are the front and we do not have much encouragement from our management because it is ... there are no role models or mentors to show us the way. We are working ...we are leaning on each other we bounce thing to each other. **SCOPE OF PRACTICE**

If we had a group of advanced practitioners that was functioning, we have nothing to look at we have not benchmark. We doing the best we can and it just by trial and error that we succeed. We would like to have an update so that we are on par with the recently trained advanced practitioners. **NEED FOR UPDATE**

9. What role do you play in the decision making of patient care?

We do have an active role to input the changes in the treatment of our patients. I think it is limited to that but it is left with the medical staff to change the treatment of the patient, but they do consult us. **ROLE OF THE NURSE**

I think it is largely dependent on who you have in your ward at a given time. We are fortunate that we have had our M.O. there for a very long time and we have built a relationship. It does become hard with the changes with the staff when they come and go. I think we do have a significant contribution to patient care **COLLABORATION/STAFF ROTATION**

I think we have allowed that to happen to us. The structure has changed for the doctor to be at the top of the hierarchy but as nurses we are refusing to work independently. We feel that everything has to go through the doctor. If see a patient that needs a psychologist there is nothing stopping me from referring the patient, but we feel that it is the doctor's responsibility to do that. I mean we should be now MDT and be on par with each other since we all have something to add. For me I feel we should be doing that but we are not allowing ourselves. We carry influence but we do not have authority. **SCOPE OF PRACTICE**

It also complicated because we get different doctors coming in. Sometimes we get the doctors who do not understand what the nurses go through and have expectations and those that feel that you are putting your nose into their domain. Our input is valued more now than it was previously. **COLLABORATION**

- *What is the current model of care?*

The biomedical model is what is often used but I do not want to rule out the psychobiocial model because we do use it. I would say it's a mixture of both.

It's is the doctor's mind-set that we are using mainly the biomedical model. I think they can't just shift. We found that in the ward round because previously we will have all the members of the team discussing the patient but now you only find the psychiatrist discussing the patient's treatment.

No.

- **Are you able to make decisions regarding implementation of health care projects?**

We are as long as you don't need anything from anyone. But if it requires resources forget about it.

- **Do you have support of the management to effect change?**

It will depend on the change that you will want to effect.

I think they have tried but they could be more.

Depends on the project because you are told you have the skills now just go and do whatever you are planning to do. I think you have more the permission than the support, because the support that you get is limited to the project at hand. (LACK OF MANAGEMENT SUPPORT)

SESSION

I did mental health nursing after which I applied and I got the post.

As for me I have been working in the psychiatric hospital for the past twenty years. When I saw the opportunity that was available I decided to apply for the post that I am in having the passion in psychiatry I applied for the post

What type of service is offered in this hospital?

Acute mental health services

it's an acute hospital

This is a specialized hospital and it caters for mental health care users who are acutely ill

What are you expected to do on a day to day basis?

To supervise the units which fall under my direct supervision? Actually checking programmes that the ward staff members are actually doing pertaining to patients ranging to so many. For the sub-acute we have programmes like psycho- educational therapy in conjunction with the therapist whereby we involved the patients as well as the family because we are preparing these patients for discharge. We see to it that these programmes are being implemented accordingly. In the acute services we are actually the core of the institution being the first stages of the user so the services that are offered its administration mostly, research and teaching because we have university learners, medical school nursing from the institutions therefore we also teach as well. We work in collaboration with the psychologist, psychiatrist, and the advance nurses we have to be seen as moving towards a specialist hospital. We take care of the KZN in Toto in terms of the patients that come to us. We are the ICU of the institution so to speak (ADMINISTRATIVE DUTIES)

Interviewer: What are psychotherapeutic interventions that are conducted in your departments?

They are acutely ill as you know that they are acutely ill you have to do psychotherapy, give them medication so that they can carry on at home. We prepare them for functioning in the community as they come from the community, from the school, from the work-place. We prepare them for going back to their families so that they come to terms with different conditions, in group form, individual therapy and there is something that was started last year where we have families involved so that when they get back they are not appalled by the behaviours that the patients present with.(ROUTINE) It also a unit which caters for first episode cases which is called North park whereby there are programmes mainly for psychotherapy where they do behaviour modification. The main people that are running the groups are the psychologists as well as the advanced psychiatric nurses.It all depends on the wards and the type of patients some the staff cannot do much psychotherapy with them

In my departments the nurses are doing basic nursing since the patients are frail and psychotherapy is not a choice of treatment for them.(MODEL OF CARE)

What level of knowledge and ability is required to perform your duties?

Well academically as a manager you need to have administration, basic psychiatry and the advance psychiatry which is a requirement since this is a tertiary institution.

Human resource management, nursing education and advance Psychiatry

I think nursing administration and diploma in psychiatry is sufficient for my position(KNOWLEDGE)

Are you in charge of any project in your department? If yes which one?

Participant: *No what we actually do is to see that the projects are actually run*

because before they implement those projects they actually present them to us to see if there are any gaps that we can identify and rectify them before the implementation of the programme.

We oversee that the programmes are run accordingly.

Our duty is to supervise the staff to ensure that programs are done. I am not aware of any projects been run in my departments (PROJECTS)

Are there policies in your department which guide your practice as an APPN?

No

No

No

What are the barriers to the fulfilment of your role?

It's actually the environment for the sorting out of the institution. Because in terms of the risk management programme we wanted the sorting which is not possible because of parameters you cannot do your risk management. Although you do the risk management, your first episode but it not possible to follow through. One of the thorny issues in practising as an advanced practitioner is the actual body that governs nursing haven't got the scope of practice in place for the advanced psychiatric nurses there is no scope of practice which guides the practice of the advance practitioner. So it is difficult to hold the nurses responsible for their responsibilities if it is not in their job description. (SCOPE OF PRACTICE)

What role do you play in the decision making of patient care?

Our involvement is when there are problematic cases which need to be discussed. We have a platform where we can exercise our rights it's called the clinical meeting whereby such cases are discussed and we have an effect to the decisions that are being taken by them. That's the forum where we address problems that adversely affect the as well as in the institution in portraying the organizational work from that complements the mhcu the problems that they encounter in their care (AUTONOMY)

because we have to consider their welfare while they are still in the institution.

The supervision is the core where we have to guide and monitor and check if it's all happening after your guidance. It is our responsibility to audit of the patients files to ensure that quality care is given. This gives us decision making powers on how the health care standards should be (ADMINISTRATIVE DUTIES)

What is the current model of care?

We used both biomedical model and psychosocial model

I think we use biomedical model more (MODEL OF CARE)

Biomedical model

Does your institution allow you to function as an autonomous individual?

In my capacity as an assistant manager I am able to take decisions regarding the functioning of my departments. There are circumstances when I need to consult. As an advance practitioner I don't have much say as I am not directly involved in the care of patients

Sometimes as the last speaker stated (COLLABORATION)

Are you able to make decisions regarding implementation of health care projects?

This is a difficult question because the advance nurses are the one that should initiate the projects and my duty is just supervision

We are not directly involved in the implementation of the projects

Not really

Do you as the management support the staff members to effect change? (PROJECTS)

A lot without a doubt. We provide them with whatever is at our disposal, we make sure that it is available to them.

We do give them a lot of support as long as they ask for it. The problem is that the nurses are not keen on doing projects so they hardly ask for support. Well shortage of resource is a big problem we are trying all we can to make motivation to get more equipment.

We do support the staff members it's just that they don't make their requisition on time because you see these things involve cash flow decisions. (MANAGEMENT SUPPORT)

SESSION5

FOCUS GROUP DISCUSSION 5

How did it happen that you were allocated to your ward?

I was just allocated by the nursing administration; I really had no say in the matter

Same as the previous speaker. We get allocated in whatever ward we have no choice

What type of service is offered in your ward?

We are female psycho-geriatric unit and we offer nursing to the geriatric patients holistically because most of them have a lot more of physical problems. We also see a lot of Alzheimer's disease and dementia. That's what most of our patients suffer from and we have chronic mental conditions like Schizophrenia who are long term and cannot be placed back to the society.

My ward is almost the same except that it is a male psychogeriatric ward. Most of our patients have grown in this hospital they were admitted when they were fairly young. Some of the patients suffer from dementia related to use of substance abuse (TYPE OF WARD)

What are you expected to do on a day to day basis?

As I was saying because with the Dementia it's degenerative so what is expected is that beside their mental illness where we have to monitor their disorientation, confusion and deal with it and have to assist with the activities of daily living and that takes up the bulk of our time. For the rest of the day we involve the mental health care user in simple activities because of the level of functioning and their concentration span which is very short and their memory which is poor so we involve them in basic activities.

Reality orientation is the main one, and then simple exercises and then simple games which are not taxing to their memory which they can do in the short space of time. Other than that it's just seeing to their basic needs e.g. personal hygiene, nutrition. We also assess them for risk of falling because as I said some of them are getting frail with the age. (ROLE OF A NURSE)

What are psychotherapeutic interventions that are conducted in your ward?

We don't do a lot. Sometimes we have patients that require behaviour modification but not all the time. But we do get them especially with the assessment patients and we do when it is warranted for those patient.

Our patients are old and just need tender love and care. (MODEL OF CARE)

Interviewer: What level of knowledge and ability is required to perform your duties?

The basic psychiatric course

I think advance psychiatry is important for me it has changed the way I look at nursing care. The skills are important and I try to teach other staff members if I have a chance (KNOWLEDGE)

Are you in charge of any project in your ward? If yes which one?

As I am saying we've done the risk assessment project which is specifically to the geriatric ward for risk assessment that all our patients need to be assessed specifically for these ward and we feel that the community is not aware of the service for geriatric patient and that's what we are doing at the moment. (PROJECTS)

We are working on a programme of community outreach to involve them because they think when the patients get admitted here they are going to get better and what they don't understand

is that you cannot reverse the degenerative process. So we are embarking on the education of the community. (PROJECTS)

Are there policies in your ward which guide your practice as an APPN?

There are no guidelines.

No direction at all

What are the barriers to the fulfilment of your role?

I think we need support so that when you come up with programmes we get support. I think also that our management are not sure of what we as advanced psychiatric practitioners are supposed to be doing. That is why we do not get much support. We initiate the programmes but if you do not get support you cannot progress. (MANAGEMENT SUPPORT)

We need policies, we need a scope of practice and we need guidelines and we would be able to function more effectively. It is very difficult for us not knowing what to do. We are also at different level of understanding as advance nurses. We need updates to keep us informed because I tell I think the ones who studied in Durban know more than us. So there is that knowledge gap (SCOPE OF PRACTICE)

What role do you play in the decision making of patient care

I would say a big role because I am part of the multidisciplinary team in the ward and I play a big role in the decision making of patient care.

I would say that the other staff members understand the patients better. Most of the time we are at meetings or doing admin work. But I do make recommendations to the MDT based on the information from my Colleagues (COLLABORATION)

What is the current model of care?

The biomedical model

The biomedical model even though most of our patients are just on (MODEL OF CARE) vitamin tablets

Does your institution allow you to function as an autonomous individual?

No

never. I think it will take some time for us to reach that level, but we do have a good MDT that we work hand in hand with. The doctors take us seriously now that we have advance diploma. They listen to us more (COLLABORATION)

Are you able to make decisions regarding implementation of health care projects?

No, we can initiate but someone else will take a decision of whether or not to implement

There is really no support there. You see the management have to be 100% behind us when we do that. We have ideas for example to do community education but we can't do that because who is going to run the ward . sometimes it's better to take the information to the community but with the shortage of staff that is not possible (MANAGEMENT SUPPORT)

Do you have support of the management to effect change?

Aaah, no.

Like I said before no.

SESSSION

Good afternoon members

Good afternoon

How did it happen that you are member of the selection committee?

As the assistant nursing manager I was elected to be part of the selection process to see that procedures are followed

I am in charge of in-service training so I was elected to the selection committee to help facilitate the process

Do you have the indicators or tools that you are using to determine the effectiveness of APPN in the provision of care?

There are no indicators or tools at all

No there are no guidelines as such but we rely on the job description which does not say much about advance nursing (TOOLS OR INDICATIONS)

What behaviour do you perceive to characterise an APPN?

I expect the advance nurse practitioner to be able to develop programmes specific to the patients that they are nursing, depending on the type of patients. Things like.... It's more different in a psychotherapy ward if you have the first episodes and you know sort of programmes like risk management in the acute, and it's not everybody that is doing it. Certain specified nursing staff with specific skills. (CHARACTERISTICS OF APPN)

I should think its strong leadership skills. As they have been to Howard through the advanced training therefore I would expect them to take a leadership role in the ward and patient care and patient management. They should be able to develop programmes and also be able to

demonstrate a very strong teaching role in the wards because of their increased knowledge and broader knowledge range gained, they really be teaching the other staff and helping them to expand their knowledge. (KNOWLEGDE)

What are your expectations? Have your expectations been met?

I expect them to function at a higher level and be exemplary in their practice. They should conduct is-service education for staff members.

I also expect them to use their knowledge in the development of projects. They should really stand out in their practice.

To answer your second question, the expectations have been met partially because they still working on some of the programmes. Some we are piloting but some have been successful.

(EXPECTATIONS)

Participant: *I don't know that I can say they have not been met, in that it is difficult when I am not in the ward to measure what teaching is taking place. There are no programmes that I am aware of or given to say these are the programmes that are being run in the wards. Whether there is or not teaching happening I would not be able to say because I have not been given anything physical to show it but that is not to say that it might not be happening(EXPECTATIONS)*

What are the barriers for the meeting the expectations?

There are not enough guidelines and there is no scope of practice. The absence of the scope of practice from the nursing council point of view makes it is very difficult for the nursing management to develop a scope of practice therefore they do not have nothing to formulate their practice on in the ward. (SCOPE OF PRACTICE)

We envisage what we would like to see them doing but we are blocked by the lack of scope of practice. If there is no scope of practice that is guiding them clearly as what to do it's only to rely on their Job descriptions which we have asked them to make them a little it different so that they include the programmes that they are running in the department. (SCOPE OF PRACTICE)

Do you as management support staff to effect change?

I would say they are given support because if they are giving a request in writing and writing down whatever motivation and the programme that they want to run, it has never been turn down because we need to see the way forward.

I believe that anything that they would come up with that they would like that is proactive would be happily welcomed and supported by management but at the moment I have not seen any request (MANAGEMENT SUPPORT)

How did it happen that you were allocated to your ward?

I did mental health nursing after which I applied and I got the post.

As for me I have been working in the psychiatric hospital for the past twenty years. When I saw the opportunity that was available I decided to apply for the post that I am in having the passion in psychiatry.

What type of service is offered in your ward?

Acute mental health services

What are you expected to do on a day to day basis?

To supervise the units which fall under my direct supervision? Actually checking programmes that the ward staff is actually doing pertaining to patients ranging to so many. For the sub-acute we have programmes like psycho- educational therapy in conjunction with the therapist whereby we involved the patients as well as the family because we are preparing these patients for discharge. We see to it that these programmes are being implemented accordingly.

ADMINISTRATIVE DUTIES)

In the acute services we are actually the core of the institution being the first stages of the user so the services that are offered its administration mostly, research and teaching because we have university learners, medical school nursing from the institutions therefore we also teach as well. We work in collaboration with the psychologist, psychiatrist, and the advance nurses we have to be seen as moving towards a specialist hospital. We take care of the KZN in Toto in terms of the patients that come to us. We are even getting those....we are the ICU of the institution so to speak. (ROLE OF A NURSE)

What are psychotherapeutic interventions (CBT, Psychotherapy) that are conducted in your ward?

They are acutely ill as you know that they are acutely ill you have to do psychotherapy, give them medication so that they can carry on at home. We prepare them for functioning in the

community as they come from the community, from the school, from the work-place. We prepare them for going back to their families so that they come to terms with different conditions, in group form, individual therapy and there is something that was started last year where we have families involved so that when they get back they are not appalled by the behaviours that the patients present with. (MODEL OF CARE)

It also a unit which caters for first episode cases which is called North park whereby there are programmes mainly for psychotherapy where they do behaviour modification. The main people that are running the groups are the psychologists as well as the advanced psychiatric nurses. (AUTONOMY)

What level of knowledge and ability is required to perform your duties?

Well academically as a manager you need to have administration, basic psychiatry and the advance psychiatry which is a requirement since this is a tertiary institution. (KNOWLEDGE)

Are you in charge of any project in your ward? If yes which one?

No

What we actually do is to see that the projects are actually run because before they implement those projects they actually present them to us to see if there are any gaps that we can identify and rectify them before the implementation of the programme. We oversee that the programmes are run accordingly. (PROJECTS)

Are there policies in your ward which guide your practice as an APPN?

No

What are the barriers to the fulfilment of your role?

It's actually the environment for the sorting out of the institution. Because in terms of the risk management programme we wanted the sorting which is not possible yen parameters you cannot do your risk management. Although you do the risk management, your first episode

One of the thorny issues in practising as an advanced practitioner is that the actual body that governs nursing haven't got the scope of practice in place for the advanced psychiatric (SCOPE OF PRACTICE)

nurses.

What role do you play in the decision making of patient care

Our involvement is when there are problematic cases which need to be discussed. We have a platform where we can exercise our rights it's called the clinical meeting whereby such cases are discussed and we have an effect to the decisions that are being taken by them. **COLLABORATION**)

That's the forum where we address problems that adversely affect the as well as in the institution in portraying the organizational work from that complements the MHCU the problems that they encounter in their care because we have to consider their welfare while they are still in the institution. The supervision is the core where we have to guide and monitor and check if it's all happening after your guidance. (ADMINISTRATIVE DUTIES

SUMMARY

Even though the process of transcription of data was time consuming and exhausting, it was a worthy exercise. The researcher had a chance to identify shortcomings e.g. the use of yes/no questions which did not allow the participants to give a detailed narration (Smith, Flowers & Larkin 2009). Some of the statements required more probing for easy understanding to the reader. Silverman (2001) argues that an exhaustive description of the data is essential for good interpretation. It is possible that my interviewing style was as effective in collecting data.

DECLARATION

I, Ronah Tholakele Zondi declare that this dissertation entitled ‘AN EXPLORATION OF STAKEHOLDERS PERCEPTIONS OF THE ADVANCE PSYCHIATRIC NURSE PRACTITIONER’S ROLE IN THE PROVISION OF HEALTH CARE IN A PSYCHIATRIC HOSPITAL AT UMGUNGUNDLOVU DISTRICT’ is my own work and has not been submitted for any other degree or examination in any other university other than the University of KwaZulu-Natal. I have given complete acknowledgment to the resources referred to in the study.

.....

Ms R. T. Zondi

(Student Number: 209521222)

.....

Date

.....

Ms A. A. H. Smith

(Supervisor)

.....

Date

DEDICATION

I dedicate this study to my family for their support and encouragement, my late mother Emily Mantombi Kunene for instilling values that have remained with me all my life. My husband, Selby Mandla Zondi for his encouragement and patience during this long and winding journey. You have been the wind beneath my wings and the pillar of my strength. Thank you Nondaba, Gagashe, Mancinza. Lastly my two lovely daughters, Noluthando and Ntokozo. Thank you for allowing me to study. I know it was a great sacrifice.

ACKNOWLEDGMENTS

My sincere gratitude and appreciation to the following:

1. My creator who gave me strength and will power to complete this research.
2. Ms A. Smith, my supervisor for her guidance, patience, encouragement and committed support.
3. Mrs N.C. Majola, the Campus principal for her motherly support
4. The KwaZulu-Natal College of Nursing for the financial assistance
5. Special thanks go to Kerry Smith and Tanozi Mkize for giving their time and providing valuable information.
6. The participants for their willingness, patience, understanding and co-operation during this research process.
7. My colleagues Luntu and Winile for encouraging me to soldier on and never to give up.

ABSTRACT

Aim

The aim of the study was to explore stakeholder's perceptions regarding the advanced psychiatric nurse practitioner's role in the provision of health care in a psychiatric hospital at uMgungundlovu district.

Methodology

A qualitative design was used to plan and implement focus group interviews. Purposive, non-probability, sampling was used to select the study setting and participants. The target population was the advanced practice psychiatric nurses (APPNs) who have completed the South African Nursing Council accredited R212 course in advanced mental health nursing (n=12) and the health care managers (n=5) who are directly involved in the selection and approval of nursing staff to complete this course. An invitation to participate was extended to all APPNs (N= 25) within the research setting and informed consent used. Thematic analysis, using the steps outlined by Braun and Clark (2006) was used to analyze the data.

Results

Most APPNs reported confusion regarding their role. The lack of guidance in the form of a scope of practice and APPN role models were reported as barriers to practice. In addition staff rotation, perceived by management to facilitate implementation of the APPN role was perceived by APPNs as a barrier to role implementation. Perceived unfair remuneration was core to APPNs reluctance to actively engage. Participating APPNs focused on managerial responsibility in the removal of barriers to role implementation and perceived management as lacking knowledge regarding the implementation of the APPN role. Management participants were generally disappointed in the APPN contribution to care.

Conclusion and Recommendations

Several factors were at play in the limited development and the implementation of the APPN role. Collaborative communication between nursing management and APPNs is recommended as the core to addressing perceived barriers and clarifying expectations. The process required for the successful implementation of APN, specifically APPN, roles is complex and dynamic. The PEPPA framework could provide a solid foundation as it articulates steps and strategies for role implementation that are relevant to APPNs and their work environments.

ABBREVIATIONS

APPN	Advance Psychiatric Practice Nurse
APN	Advance Practice Nurse
ARNP	Advance Registered Nurse Practitioner
DOH	Department of Health
CNS	Clinical Nurse Specialist
GP	General Practitioner
MDG	Millennium Developmental Goals
MHCU	Mental Health Care User
OSD	Occupational Specific Dispensation
PN	Professional Nurse
RCNA	Royal College of Nursing Australia
SANC	South African Nursing Council
WHO	World Health Organization

TABLE OF CONTENTS

Declaration	ii
Dedication	iii
Acknowledgments	iii
Abstract	iv
Abbreviations	v
Table of Contents	vi

LIST OF FIGURES

Figure: 1 – PEPPA Framework	11
------------------------------------	----

LIST OF TABLES

Table 4.1 – APPN Demographic Data	41
--	----

Table 4.2 – Management Demographic Data	42
--	----

TRANSCRIPTS 80

Annexure A – Letter requesting institutional support

Annexure B – Approval from institution

Annexure C – Letter to participants

Annexure D – Letter to the Department of Health

Annexure E – Approval from the Department of Health

Annexure F – Approval from UKZN

Annexure G – Consent form

Annexure H – Interview guide – demographic data

Annexure I – Central Questions

Annexure J – Emergent themes

Annexure K - Transcripts

Annexure L – Raw Data

CONTENTS

CHAPTER 1: INTRODUCTION TO THE STUDY

1.1 Introduction.....	1
1.2 Background Information to the study.....	1
1.3 Statement of the problem.....	6
1.4 Purpose of the Study... ..	6
1.5 Research Objectives and questions.....	7
1.6 Significance of the Study.....	8
1.7 Operational Terms.....	8
1.8 The Theoretical Framework.....	10
1.8.1 Introduction.....	10
1.8.2 The unfolding of the framework in this study.....	15
1.9 Summary of the chapter.....	15

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction.....	16
2.2 Historical and current perspective.....	16
2.3 What shall the name be	19
2.4 Role extension, expansion and development.....	21
2.5 Competencies, characters and educational requirement.....	23
2.6 Credentialing.....	25
2.7 Professional development and health care outcomes.....	26
2.8 Summary of the chapter	28

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction.....	30
3.2 Research paradigm	30
3.3 Research Design.....	30
3.4 Research Setting.....	31
3.5 Population and target population.....	32
3.6 Sample and sample procedure.....	32
3.7 Data collection procedure.....	33
3.8 Data analysis.....	34
3.9 Trustworthiness, dependability and academic rigour.....	35
3.10 Ethical considerations.....	37
3.11 Data Management.....	39
3.12 Data Dissemination.....	39
3.13 Summary of the chapter.....	39

CHAPTER 4: DATA PRESENTATION AND ANALYSIS

4.1 Introduction.....	40
4.2 Description of the participants and their work setting.....	40
4.3 Braun and Clarke method of data analysis.....	42
4.3.1 Familiarizing self with the data and generating initial codes.....	42
4.3.2 Searching for codes.....	43
4.3.3 Reviewing themes identifies and defining and naming themes.....	43

4.4 Themes	
4.4.1 Theme 1: One dimensional role.....	44
4.2.2 Theme 2: Collaboration.....	44
4.1.3 Theme 3: Model of care.....	46
4.1.4 Theme 4: Educational preparation and update.....	47
4.1.5 Theme 5: Expectations, scope of practice / practice guidelines.....	50
4.1.6 Theme 6: The controversy of the occupational specific dispensation.....	54
4.1.7 Theme 7: Organizational support.....	56
4.4 Summary of the chapter.....	56

CHAPTER 5: DISCUSSION AND RECOMMENDATIONS

5.1 Introduction.....	58
5.2 Discussion.....	58
5.2.1 Desirable knowledge and skill.....	58
5.2.2 Facilitating the implementation of the role.....	59
5.2.3 Expected benefits of the APPN role.....	61
5.3 Researcher’s reflexivity and study limitations.....	62
5.4 Recommendations	
5.4.1 Implications for nursing practice.....	64
5.4.2 Nursing policy makers.....	65
5.4.3 Nursing Education.....	65
5.4.4. Nursing research.....	65
5.5 Summary.....	66
5.6 Conclusion.....	66
6. References:	67

TRANSCRIPTS

Annexure A – Letter requesting institutional support.....	80
Annexure B –Approval from institution.....	82
Annexure C – Letter to participants.....	83
Annexure D – Letter to the Department of Health.....	84
Annexure E - Approval from the Department of health.....	86
Annexure F – Approval from UKZN.....	87
Annexure G – Consent form.....	88
Annexure H – Interview guide – demographic data.....	89
Annexure I – Central questions.....	90
Annexure J – Emergent Themes.....	91
Annexure K - Transcription of interviews held with participants of the study focus group discussion 1, 2, 3, 4, 5 and 6.....	92
Annexure L – Raw Data.....	132